



**UNIVERSITY OFTM
KWAZULU-NATAL**

**INYUVESI
YAKWAZULU-NATALI**

“Let’s talk about sex baby” - A comparative study of
parents’ perceptions of parent-child sexuality
communication with their adolescent children in rural and
urban settings in eThekweni Municipality, KwaZulu-Natal.

Nompumelelo Promise Gumede

8729208

Supervisor
Dr. Eliza Govender

Dissertation submitted to the
Centre for Communication, Media and Society,
University of KwaZulu-Natal,
in fulfilment of the requirements for the degree of
Master of Social Science

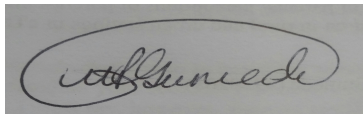
2017

COLLEGE OF HUMANITIES

Declaration - Plagiarism

I, Promise Nompumelelo Gumede, student number: 8729208, hereby declare that the research reported in this dissertation, except where otherwise indicated, is my original research; this dissertation has not been submitted for any degree or examination at any other university; and this dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons. This dissertation does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers; where other written sources have been quoted, i) their words have been re-written, but retains the meaning and is referenced, ii) where their exact words have been used, then their writing has been placed in quotation marks and referenced. I also declare that this dissertation does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the dissertation and in the Reference section.

Signature



Date: 08 March 2018

Supervisor



Date: 08 March 2018

Dedication

This is dedicated to the memory of my late father, Timothy Bhekithemba Maluleka, who inspired his daughters to always reach for the skies. Rest in peace baba, the fruits of your labour are evident for all to see.

To my mother, Sylvia Sibongile Maluleka, for her prayers and for being a strong pillar of support.

To my sisters and brothers, whom I love dearly – thank you for your support maThomoyi.

To my children, Nolwazi, Khwezi and Nkazimulo Gumede – may this inspire you to also reach for the skies.

To my husband and best friend for his unwavering support and encouragement – *uyindoda emadodeni, Qwabe!*

Acknowledgements

Thanks and praise go to the almighty Creator for strength and wisdom to see this project through.

Thanks and appreciation also goes to my supervisor, Dr. Eliza Govender, for the amazing support and guidance throughout the process of conducting this research. Thank you for demonstrating the true essence of women empowerment. Indeed, *umuntu ngumuntu ngabantu!*

I thank my editor for his editing work on this dissertation.

The support provided by my husband, Mkhonzeni Gumede, throughout the period of my studies has been immeasurable. *Ngiyabonga Mpangazitha, Qwabe, Yeyeye, phakade lam!* Thanks also goes to my children for their understanding for the duration of this study period.

I would like to thank the research participants and organisations that facilitated access to the research locations and participants for this study: DramAidE, Faith and Hope Community organization, Umnini, the Congregational Church of Queensburgh.

To the Centre for Communication, Media and Society (CCMS) students and staff – thank you for the rigorous and vibrant discussions that sharpen our academic insight.

Abstract

In South Africa, the teenage pregnancy prevalence rate stands at 47 births per 1000 girls per annum for girls aged between 15 and 19 years, as opposed to 15 per 1000 girls in the United Kingdom (UK), and 24 per 1000 girls in the United States (US). Unintended adolescent pregnancies pose threats not only to the adolescent, but also to the adolescent's family, community and country. There is worldwide agreement that ending adolescent pregnancies should be part of national strategies for poverty reduction and social justice, as they undermine the achievement of several Goals for Sustainable Development (SDGs).

Parent-child communication on sexuality has been shown to improve sexual and reproductive outcomes in adolescents. However, little research is available to indicate the effectiveness of this approach within the African context, more specifically, the KwaZulu-Natal context in South Africa. This study explores Zulu speaking parents' perceptions of parent-child communication on sexuality in a rural area, Umnini, and in an urban area, Queensburgh in KwaZulu-Natal, South Africa.

Using a qualitative approach to research, involving focus group discussions (FGDs) with rural and urban Zulu-speaking parents, selected using non-random sampling, this study explores parents' perceptions of parent-child communication on sexuality. Framed through the theoretical lens of Mohan Dutta's Culture-Centred Approach (CCA) to health communication, and Kincaid et al's Social Ecology Model for Communication and Health Behaviour (SEMCHB), findings reveal that the cultural context influences parental communication on sexuality, and that parent-child communication on sexuality needs to be embedded within a multi-level approach to health communication at the individual, social, community and policy levels.

Key words: Parent-child communication, adolescent sexuality, parenting, teenage pregnancy, HIV, AIDS

List of Acronyms and Abbreviations

AA-HA!	Global Accelerated Action for the Health of Adolescents
AIDS	Acquired Immuno-Deficiency Syndrome
ASRH&R	Adolescent Sexual and Reproductive Health and Rights
ASRHE	Adolescent Sexual and Reproductive Health Education
AU	African Union
AYHP	National Adolescent and Youth Health Policy
CBO	Community-Based Organisation
CCA	Culture-Centred Approach
CCQ	Congregational Church of Queensburgh
CD	Compact Disc
CHAMP	Collaborative HIV/AIDS and Adolescent Mental Health Programme
DBE	Department of Basic Education
DOH	Department of Health
DSD	Department of Social Development
ESA	Eastern and Southern Africa
FGDs	Focus Group Discussions
HIV	Human Immuno-Deficiency Virus
HSRC	Human Sciences Research Council
KZN	KwaZulu-Natal
NDOH	National Department of Health
NGOs	Non-Governmental Organisations
PHD	Doctor of Philosophy
SA	South Africa
SDGs	Sustainable Development Goals
SEMCHB	Social Ecology Model of Communication and Health Behaviour
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STATSSA	Statistics South Africa
STIs	Sexually Transmitted Infections
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS.
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
WHO	World Health Organisation

List of tables and figures

List of tables

Table 4.1: Methodological Map of the study.....73

Table 4.2: FGD participants for the study.....81

Table 4.3: Thematic Analysis Map..... 85

List of figures

Figure 3.1: SEMCHB..... 49

Table of Contents

Declaration on Plagiarism	i
Dedication	ii
Acknowledgements	iii
Abstract	iv
List of Acronyms and Abbreviations	v
CHAPTER ONE - INTRODUCTION	1
Introduction	1
Background to the study	4
Rationale for the study	5
Objectives	7
Specific objectives	7
Research questions	7
Structure of the dissertation	8
CHAPTER TWO - LITERATURE REVIEW	11
Introduction	11
Adolescence	12
Sexuality	13
Adolescent health	14
Adolescent Sexual and Reproductive Health (ASRH)	15
Health communication	19
Communication strategies that have been used to address adolescent SRH at regional level	20
Parent-child communication on sexuality	22
Parents' perceptions of parent-child communication on sexuality – a global perspective	26
Parents' perceptions of parent-child communication on sexuality in the African context	29
Barriers to parent-child communication on sexuality	32
Enabling factors to parent-child communication on sexuality	33
Conclusion	36
CHAPTER THREE - THEORETICAL FRAMEWORK	37
Introduction	37
The Social Ecology Model for Communication and Health Behaviour	38
The Culture-Centred Approach to health communication	45
Agency	54
CHAPTER FOUR - RESEARCH METHODOLOGY	63
Introduction	63
The research paradigm	63
Research design	66
Research setting	67
Sampling	68
Recruitment strategy	70
Data collection	71
Defining focus group discussions	71
Rationale for using focus group discussions	72
Group selection	72
Group size	74

Standardisation.....	75
Number of groups	75
Data analysis.....	76
Ethical considerations.....	78
Language.....	79
Gatekeeper access	79
Participant consent.....	79
Recording	80
Accessibility of the venue.....	80
Validity, reliability and trustworthiness of the research.....	80
Limitations to the study.....	81
CHAPTER FIVE - DATA PRESENTATION AND ANALYSIS.....	83
Introduction	83
Parents' current approaches to parent-child communication on sexuality.....	85
Adolescents do not reciprocate communication by parents	85
Silence and avoidance	87
Parents use fear tactics, threats and warnings.....	89
Communication by parents is highly gendered.....	90
Parents are selective in communicating on issues of sexuality.....	94
Using the media to facilitate parent-child communication on sexuality	98
Factors that influence parent-child communication	99
The influence of upbringing on parent-child communication on sexuality.....	100
The influence of culture on parent-child communication on sexuality.....	103
The influence of religion on parent-child communication on sexuality.....	106
Access to resources and information on sexuality	107
Adolescents avoid communication with parents	110
Perceptions of parents on parent-child communication	111
Perceptions on the role of parents in communication on sexuality.....	111
Perception that communication promotes earlier onset of sexual activity.....	114
Parents' strategies for becoming more effective in communicating.....	115
Platforms for learning	115
Conclusion.....	116
CHAPTER SIX - DISCUSSION OF FINDINGS.....	118
Introduction	118
Objective 1	118
Objective 2	124
Objective 3	127
Conclusion.....	129
CHAPTER SEVEN - CONCLUSION	132
Introduction	132
Summary of key findings	133
The nature of parent-child communication on sexuality	133
Cultural and structural factors that influence parent-child communication on sexuality	134
Factors for success	134
Limitations of the study.....	135
Recommendations for further research	136
Appendices	138
Appendix 1: Ethical Clearance Letter.....	138
Appendix 2: Gatekeeper letter 1	139
Appendix 3: Gatekeeper Letter 2	140

Appendix 4: Informed Consent Form - English.....	141
Appendix 5: Informed Consent Form - IsiZulu	143
Appendix 6: Focus Group Discussion Guide	145
Bibliography	148
Primary Sources.....	148
Secondary Sources	148

CHAPTER ONE - INTRODUCTION

Introduction

This study explores the concept of parent-child communication on sexuality within a South African context, in particular with urban and rural, older and younger parents in eThekweni Municipality. This study explores the concept of parent-child communication on sexuality, as a strategy that can be employed in addressing unacceptably high levels of adolescent pregnancies. This chapter discusses the background to the study, the research problem, and the rationale to the study. In addition the study aims, objectives and research questions are outlined. The chapter concludes with a breakdown of the chapters contained in the dissertation, as well as a brief explanation of the contents of each chapter.

It is estimated that one fifth of the world's population – about 1.2 billion people - are adolescents (10-19 years old), and 85% of them are in the developing world (Loaiza & Liang, 2013). While it can be argued that adolescence is a time of unprecedented promise due to the rapidly widening world of opportunities for them, the reality for the majority of adolescents worldwide is that this widening world also exposes adolescents to serious risks before they have adequate information, skills and experience to avoid or counteract them (WHO, 2007). One such area of adolescent vulnerability is their sexual and reproductive health.

An estimated 16 million girls aged between 15 and 19 years give birth each year, which is about 11% of all births worldwide (Blum & Gates, 2015). While adolescents between the ages of 10 and 19 years account for 11% of all births worldwide, they account for 23% of the overall burden of all diseases globally (Ganchimeg, Ota, Morisaki, Laopaiboon, Lumbiganon, Zhang, Yamdamsuren, Temmerman, Say & Tuncalp, 2014). An estimated 2.5 million adolescents have unsafe abortions every year, and many die, while those that

survive experience more adverse reproductive health consequences than women in their twenties (Ganchimeg *et al*, 2014).

In Sub-Saharan Africa, adolescents and young people aged 10 to 24 years make up an estimated 33% of the total population (UNESCO, 2013). Data from the Sub-Saharan region reveals adolescent fertility rates of 108.2 live births per 1000 girls aged 15 to 19 years, which is two times higher than the world average of 53.4 live births per 1000 girls (UNESCO 2013). Unintended pregnancies remain a huge challenge in this region, with many adolescents not using contraception despite having knowledge about it (Loaiza & Liang, 2013). In addition, unsafe abortion rates are high, with girls under the age of 20 years accounting for 70% of all unsafe abortions in Sub-Saharan Africa (Laoiza & Liang, 2013). With increased sexual activity among adolescents, there is increased exposure to sexually transmitted infections (STIs) including Human Immunodeficiency Virus (HIV). Sub-Saharan Africa remains the most severely affected by HIV, with the region accounting for 62% of people living with HIV worldwide (UNAIDS, 2017).

In South Africa, a report on the situation of teenage pregnancy, commissioned by the South African Department of Basic Education (DBE) in 2009 acknowledged that while overall fertility rates had declined over several years, this decline was lower in the adolescent age group (10-19 years) (Panday, Makiwane, Ranchod & Letsoala, 2009). The recent policy brief released by the Human Sciences Research Council (HSRC) in 2016, indicated that the teenage pregnancy prevalence rate stands at 47 births per 1000 girls per annum for girls aged between 15 and 19 years, as opposed to 15 per 1000 girls in the United Kingdom (UK), and 24 per 1000 girls in the United States (US) (Reddy, Sewpaul & Jonas, 2016).

Recently, in 2016, figures released by Statistics South Africa (StatsSA) revealed that 16% of women aged 15-19 in South Africa have begun childbearing, while 12% have given birth, and a further 3% were pregnant with their first child in 2016 (StatsSA, 2017). The same report also states that the three provinces with the highest percentages of women that have begun

childbearing are Northern Cape and North West, both at 20%, and KwaZulu-Natal at 19%. What is of further concern in this report is the fact that “overall, the percentage of women aged 15-19 who have begun childbearing is unchanged relative to 1998 (16% in both 1998 and 2016)” (StatsSA, 2017:12). Additionally, adolescents in rural areas are said to have higher percentages (19%) of childbearing between the ages 15-19 years than adolescents in urban areas (14%) (ibid).

The HSRC 2014 report on the South African National HIV prevalence, incidence and behaviour survey further revealed that early sexual debut has increased for boys between 2008 and 2012, with early sexual debut being defined as sex before the age of 15 years (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios & Onoya, 2014).

This state of affairs poses challenges firstly for the adolescents themselves, as their educational prospects and economic opportunities are adversely affected (Sedgh, Finer, Bankole, Eilers & Singh, 2015). Secondly, early and unplanned pregnancies limit young girls’ prospects for contributing to household finances, as well as to their local and national economies (Merrick, 2016). Thirdly, any pregnancy is a sign of lack of use of protection during sexual intercourse, such as female or male condoms, which are the main methods of protection against HIV infection. Whilst it is known that about two thirds of adolescents living with HIV in 2015 acquired it during their mothers’ pregnancies, one third of HIV-infected adolescents were affected as adolescents through unsafe sexual behaviour, with more than 250 000 adolescents between the ages of 15 and 19 years having been newly infected in 2015 (WHO, 2017).

The above point to the need for an intensified response to assist adolescents and youth to effectively manage their sexual and reproductive health for better overall health outcomes. Such a response requires actions at global, regional and local levels to influence policy that prioritises adolescent sexual and reproductive health, as well as interventions that target not only the individual,

but also the social, community, and the broader policy environment (Chandra-Mouli, Camacho & Michaud , 2013).

The focus of this study is on the interpersonal level of influence with parents. The study investigates perceptions of parents on parent-child communication on sexuality in the rural and urban contexts of eThekweni Municipality in KwaZulu-Natal, and with younger and older parents in both contexts. It is envisaged that such a study will increase understanding of this phenomenon from the parents' perspective, and will add to the body of already-existing knowledge on parent-child communication within an African cultural context.

Background to the study

Whilst many interventions are being implemented to address high adolescent pregnancy levels, it is clear that more effort and additional strategies need to be employed towards this goal. There is an increasing call globally for a multi-level approach that targets not only the adolescents themselves, but one that is also targeted at the family, community and policy levels (Blum & Gates, 2015).

The role of parents is increasingly being seen as a crucial component that can further advance the cause to decrease high levels of adolescent pregnancy (Laoiza & Liang, 2013; UNFPA, UNESCO & UNAIDS, 2015; WHO, 2017). Studies that explore parent-child communication are increasing in number both regionally in Africa, and locally in South Africa (Akinwale, Adeneye, Omotola, Manafa, Idowu, Adewale, Sulyman & Akande , 2009; Bhana, Petersen, Mason, Mahintsho, Bell & McKay , 2004; Bastien, Kajula & Muhwezi , 2011; Namisi, Flisher, Overland, Bastien, Onya, Kaaya & Aaro , 2009; Phetla, Busza, Hargreaves, Proynk, Kim, Morison, Watts & Porter 2008; Wamoyi, Fenwick, Urassa, Zaba & Stones , 2009).

This study explores the perceptions of parents on parent-child communication in two areas in eThekweni Municipality, KwaZulu-Natal, one being rural and the other being an urban area. The rural area is Umnini, which is located

about 45 kilometres south of Durban, and the urban area is Queensburgh, which is situated west of Durban. As already demonstrated from the statistics published by StatsSA (2017), the percentage of women between the ages of 15 and 19 years who have begun childbearing is higher in rural than in urban areas in South Africa. It is the interest of this study, therefore, to explore the perceptions of parents in both rural and urban areas, and to ascertain how these are similar or how they differ. Other researchers have articulated the need for research that explores rural/urban differences in health issues (Eberhardt & Pamuk, 2004; Lurie, Proynk, De Moor, Heyer, De Bruyn, Struthers, McIntyre, Gray, Marinda & Klipstein-Grobusch, 2008; Peltzer, 2006; Pinderhughes, Nix, Foster & Jones, 2001).

This study further explores perceptions of parents based on their age. Both rural and urban parents are further categorised into younger (45 and below) and older (45 and above) parents. A study by Akinwale *et al* (2009) revealed that younger parents experience fewer inhibitions in communicating with their adolescent children on issues of sexuality than their older counterparts. However, this finding was made with parents in Nigeria (West Africa), which is a context that is different to that of this study (KwaZulu-Natal, South Africa). This study aims to explore this dynamic, in order to ascertain whether this is similar with parents in this context.

While this study does not seek to formulate recommendations for future practice of parent-child communication on sexuality, it is hoped that the study will add to the existing body of literature on this phenomenon, as studies of this nature are currently few especially within an African context, and more so within a South African cultural context.

Research problem

In light of the above, it is clear that research into the phenomenon of parent-child communication on sexuality is needed, particularly within the African context. There is an increase in interest on programmes that target parents to enable them to communicate with their children about sexuality. If such programmes are going to succeed, it is imperative that they take into

consideration the unique cultural and contextual factors that may influence its success.

The problem statement of this study is therefore to investigate the perceptions of parents in rural and urban areas in eThekweni Municipality and to establish whether there are differences in perceptions between rural and urban parents, as well as between younger and older parents in both settings.

Rationale for the study

It is accepted globally that interventions aimed at reducing the unacceptably high levels of adolescent pregnancy need to be strengthened (WHO, 2017). With figures indicating that adolescents in the African context are more disproportionately affected by adolescent pregnancy than adolescents in other contexts, it is becoming increasingly important to investigate a variety of strategies that can be employed to decrease adolescent pregnancy rates, particularly with regards to their application within the African cultural context (UNFPA, UNESCO & UNAIDS, 2015).

The concept of parents communicating with their children on issues of sexuality has been explored in various Western contexts and proven to show some promise, with studies indicating that it does impact positively on adolescent sexual and reproductive health outcomes (Chandra-Mouli *et al*, 2013; WHO, 2007; 2017). However, studies are still emerging on this concept in the African context, with very few studies available to determine the value and effectiveness of such an approach (Bastien *et al*, 2011).

Research Aim

The overall aim of this study is to explore the perceptions that parents have of the concept of parent-child communication, and to establish whether there are differences in perceptions between urban and rural, as well as younger and older parents in eThekweni Municipality.

This study adds to the body of scant, but already available body of knowledge on parent-child communication on sexuality, and seeks to do so from an

African cultural perspective. The study is framed within the discipline of health communication, and explores parent-child communication on sexuality as a form of interpersonal health communication that holds promise as a strategy that can be further added to the arsenal of currently existing efforts to curb unintended adolescent pregnancies.

Research Objectives

The aim of this study is to explore the perceptions of parents about parent-child sexuality communication with their adolescent children. More specifically, the study aims to compare two sets of parents in different social contexts and age cohorts, i.e. rural and urban; and younger and older parents, to ascertain if there are any differences/similarities and the nature of this variances, if any.

Specific objectives

1. To establish if parents are communicating with their adolescent children on issues of sexuality and to establish the nature of this communication, where it is happening;
2. To explore the factors that parents perceive as enabling or restrictive in establishing and maintaining parent-child sexuality communication;
3. To identify factors that parents perceive as necessary for them to be able to initiate and maintain parent-child sexuality communication with their adolescent children.

Research questions

The existing literature on parent-child communication on sexuality, as well as the theoretical framework that has been applied, inform the research questions for this study, which are based on the objectives thereof.

1. What is the nature of parent-child sexuality communication amongst rural and urban parents of Ethekewini Municipality in KwaZulu-Natal?
2. What are the structural and cultural factors that promote or inhibit effective parent-child sexuality communication between parents identified for this study and their adolescent children?

3. What factors do these parents perceive to be necessary for them to be effective in initiating and/or maintaining effective parent-child sexuality communication with their adolescent children?

It is envisaged that answers to these research questions will add to the already existing body of knowledge on parent-child communication on sexuality in the South African context. Answers to the research questions will further provide insight into the factors that influence parent-child communication on sexuality, and will provide insight into whether parents display any agency in negotiating this oftentimes-nebulous territory of communication on sexuality with their adolescent children.

Structure of the dissertation

This dissertation comprises six chapters. The chapters are organised in such a way as to provide an overview of literature, the theoretical framework, the research methodology, data presentation and analysis, discussion of findings, as well as the conclusion that summarizes key learning and insights from the study.

Chapter One – Introduction

This chapter presents an overview of the phenomena, adolescent pregnancy as both a global and national problem that needs urgent redress at different levels. Parent-child communication on sexuality as a concept is introduced as one of the solutions to addressing unacceptably high levels of adolescent pregnancy. The chapter also presents the rationale for the study research objectives and research questions.

Chapter Two – Literature review

This chapter provides an overview of the relevant literature that explores adolescent sexual and reproductive health. Key international, regional and local policy instruments that guide practice on adolescent sexual and reproductive health are explored for their contribution to informing interventions that include the family level as part of the overall strategy for addressing the challenge of adolescent pregnancy. Definitions of key terms

are also provided. The chapter also explores literature on parent-child communication on sexuality from a global, regional and local (South African) perspective. Cultural and structural barriers and enablers to parent-child communication on sexuality are explored, and the literature review also investigates possible future directions for research on the phenomenon under study.

Chapter Three – Theoretical framework

This chapter provides an in-depth discussion of the theoretical underpinnings that inform this study. It is grounded upon Kincaid, Figueroa, Storey & Underwood's (2007) Social Ecology Model for Communication and Health Behaviour (SEMCHB), and Dutta's (2008) Culture-Centred Approach (CCA) to health communication. The SEMCHB is applied for its usefulness in placing the concept of parent-child communication on sexuality within a broader framework of a multi-level approach to addressing the challenge of adolescent pregnancy. While it is the concept of parent-child communication on sexuality that is under investigation in this study, the relevance of the theory is in its application as an interpersonal health communication strategy that should not be seen in isolation, but as part of a broader strategy towards decreasing adolescent pregnancy.

The CCA is applied in this study to explore the key constructs of culture, structure and agency, and how these inform how parents navigate the complex phenomenon of parent-child communication on sexuality. It is the assertion of the CCA that communities have the agency and ability to frame health communication strategies in their own cultural perspectives, when provided with the opportunity to engage in meaningful dialogue (Dutta, 2008; 2011).

Chapter Four – Research Methodology

This chapter describes the research methodology used, providing the reader with an insight into the research paradigm that informs the study, which is interpretive research. The chapter also stipulates the research design used (qualitative), selection of participants (sampling), data collection method used

(focus group discussions), as well as a rationale for their use, the data analysis method used, which is thematic analysis. The chapter ends with a discussion on issues related to the trustworthiness of the study, and finally a description of how ethical issues were addressed.

Chapter Five - Data presentation and analysis

This chapter presents the data that was collected through focus group discussions (FGDs). It further provides an analysis of the data in a way that sheds light on the perceptions of parents on parent-child communication on sexuality. The discussion of findings is organised in a way that elucidates the differences and similarities in perceptions across the four groups of parents that were part of the study. The data analysis is further linked to the research questions, as well as to the theoretical framework for the study.

Chapter Six – Discussion of findings

This chapter provides an in-depth discussion of the findings from the study, and does so based on the research objectives of the study, as well as the theoretical framework applied to the study.

Chapter Seven – Conclusion

This chapter presents the conclusions made as a result of the analysis of the data, and further provides limitations to the study and opportunities for further research on the topic.

CHAPTER TWO - LITERATURE REVIEW

Introduction

Early and unplanned pregnancy is an issue of global concern (WHO, 2017). According to the United Nations Fund for Population Activities (*UNFPA*) *report on Adolescent Pregnancy* published in 2013, “pregnancies among girls less than 18 years of age have irreparable consequences, as they violate the rights of girls, with life-threatening consequences in terms of sexual and reproductive health” (Laoiza & Liang, 2013:3). In addition to this, the World Health Organisation (WHO) (2017) has categorically stated that unabated adolescent pregnancy rates pose a threat to the achievement of the Sustainable Development Goals (SDGs), as they contribute to the perpetuation of the cycle of poverty, resulting in high development costs for communities.

In light of the above, calls have been made for a more concerted effort to curb unplanned adolescent pregnancies worldwide. Efforts to address escalating adolescent pregnancy rates have been implemented in various contexts, and have included a variety of different interventions including school-based programmes, peer-to-peer programmes, community-based programmes, programmes for youth out of school, programmes involving families, and many others (Chandra-Mouli *et al*, 2013). Over the years, research has shown that interventions that are once-off, are implemented in isolation, and which ignore the cultural context in which adolescents live, are not effective in changing harmful behaviours or influencing social norms that perpetuate adolescent pregnancy (Chandra-Mouli, Lane & Wong, 2015)

Approaches that have been found to be more effective are those that are implemented across multiple levels of influence, including policy and regulatory frameworks, family and community norms, interpersonal relations and economic influences (Chandra-Mouli *et al*, 2013; Sallis, Owen & Fisher, 2015). The particular focus of this study is on the involvement of families and their role in impacting on the sexual and reproductive health outcomes for

adolescents. Parent-child communication on sexuality is increasingly getting recognised as an important component of a comprehensive, integrated and multi-level response aimed at curbing adolescent pregnancies. It has been advocated for in various global and sub-regional policy documents that address adolescent sexual and reproductive health (ASRH) issues, including the African Union Commission's *Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR)* of 2006, the *Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030)* of 2015, the Eastern and Southern African (ESA) *Ministerial Commitment Process* of 2013, and the United Nations Educational, Scientific and Cultural Organisation (UNESCO), 2013.

This chapter explores literature on parent-child communication on sexuality, particularly within an African cultural context. However, the chapter starts with an exploration of literature on adolescent sexual and reproductive health, particularly with respect to unplanned adolescent pregnancy and its repercussions in the African context. The chapter also explores health communication and its relationship to parent-child communication on sexuality. The chapter starts with the unpacking of key terms used throughout this dissertation, namely, adolescence, sexuality, sexual and reproductive health, parents and parent-child communication.

Adolescence

The term *adolescence* is one that has proved difficult to define for scholars and practitioners worldwide. A common definition of adolescence is that of the transition period from childhood to adult life (Kaplan, 2004). However, some scholars argue that this definition is problematic as this time frame does not take one singular form in all individuals across different contexts and cultures (Degner, 2006; Manaster, 1989). As Degner points out, this transition from childhood to adulthood “varies considerably across cultures, over time, and within individuals.” (2006:7)

While some scientists may tend to define adolescence based purely on physical changes that are characteristic of this growth stage, Manaster (1989)

argues that such an understanding of adolescence is limited and implies a universality that is not true for everyone, everywhere in the world. He proposes a more comprehensive definition of adolescence that takes into consideration the physical, psychosocial, cognitive, social, and other developmental aspects of being.

In the context of this complexity of definitions regarding adolescence, the United Nations Children's Fund (UNICEF) (2011) has offered a definition of adolescence that focuses on the age of the adolescent child. This is the period of life between the ages of 10-19 years of age. This is despite acknowledging that "each individual experiences this period differently depending on her or his physical, emotional and cognitive maturation as well as other contingencies" (UNICEF, 2011:8). This age bracket of 10-19 years often referred to as the second decade of life, is normally associated with the onset of puberty in children. However, as much as puberty can be seen as a clear line demarcating the transition from adolescence to adulthood, this does not adequately solve the dilemma of defining adolescence. So, in essence, this definition is based largely on the idea of 'the age of majority', which is the legal age at which an individual is recognised as an adult; mostly 18 years of age in most countries worldwide.

For the purposes of this study, the UNICEF definition of adolescence is adopted, as it is widely accepted that adolescence is the second decade of an individual's life (UNICEF, 2011). This makes it possible for developmental interventions to target programmes aimed at adolescents appropriately, and to provide special attention and protection to adolescents as needed.

Sexuality

The World Health Organisation (2006) has provided a working definition of sexuality, which states that sexuality is:

A central aspect of being human throughout life (that) encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. (WHO, 2006:5)

In other words, sexuality is not just one thing, but a combination of different aspects of being for both males and females. It is clear from the above definition that sexuality is not only complex, but also involves a variety of issues pertaining to being male or female.

Adolescent health

There is now, more than ever, an increasing call for more urgent actions to be taken to safeguard the health and well-being of all adolescents, due to the recognition that “investing sufficiently to fully promote and protect adolescent health and well-being is key to sustainable development” (WHO, 2017:1). While it is a documented fact that adolescents in the world today are generally healthier than in previous generations, evidence shows that much more effort is required to ensure positive health outcomes for all adolescents in different nations worldwide (UNICEF, 2011).

Key adolescent health issues that have been identified as needing particular attention are varied and wide-ranging. In its *State of the World's Children Report*, the UNICEF (2011) identified accidents, malnutrition, inadequate assistance with disability or injury, violence, human immune virus (HIV) and other sexually transmitted infection (STIs), mental health problems, water, sanitation and hygiene needs, and sexual and reproductive health, including early and/or unintended pregnancy, as some of the major risks to adolescent health and survival. The detrimental effects of lack of action to safeguard adolescent health have far-reaching consequences both for adolescents and the rest of the world populations. As the WHO (2017) outlines, failure to act

by governments will have detrimental effects for adolescents themselves, their future, and that of their children.

The World Health Organisation (2017) recently released the *Global Accelerated Action for the Health of Adolescents (AA-HA!) – Guidance to Support Country Implementation*, a document that provides guidelines and suggestions for concrete actions by governments to accelerate actions designed to safeguard the health of adolescents. In the same document, the WHO argues that failure to act to promote the health and well-being of adolescents will have an adverse effect on the realisation of the 2030 Agenda for Sustainable Development.

This study has a particular focus on one, but equally important aspect of adolescent health, namely, adolescent sexual and reproductive health. Of particular concern in the study is adolescent pregnancy, which is a hindrance to adolescents and their children, and that has detrimental effects with likely links to poverty (Merrick, 2016).

Adolescent Sexual and Reproductive Health

SRH is defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes” (Merrick, 2016:2). Evidence shows that access to SRH information, services and care to help adolescents manage pubertal changes and avoid or delay pregnancy, leads to adolescents completing more years of school, being better prepared to contribute to household finances later in life, ultimately resulting in them contributing to local and national economies (Gay, 2017).

In the publication titled *Making The Case For Investing In Adolescent Reproductive Health*, Merrick (2016) outlines some linkages between early childbearing and poverty as follows:

- Poor health outcomes for the young mother and her child, including higher risk of obstetric complications, leading to higher maternal

mortality or higher disease and disability if she survives; increased risk of abortion and complications related to unsafe abortions; low birth weight and other problems for the newborn.

- Poor educational outcomes for both the mother and her child, including dropping out of school and less schooling for the child.
- A lower and/or altered consumption pattern within the mother's immediate and extended family related to the costs of rearing the child.
- Lower labour force participation by the young mother, with less opportunity to contribute to household income.
- Reduced acquisition of social capital (smaller social network and/or less influence within networks) through reduced community participation and greater chances of divorce or single parenthood.

The World Health Organisation further reports that the two leading causes of death in adolescent girls between the ages of 15 and 19 years are suicide and complications during pregnancy and childbirth (WHO, 2017).

The need to safeguard the sexual and reproductive health of adolescents is therefore recognised globally as an imperative. As a result, various instruments have been tabulated and adopted by countries in efforts to ensure that adolescent sexual and reproductive health is prioritised in the global policy landscape. The year 2015 saw the Millennium Development Goals coming to an end and being replaced by the Sustainable Development Goals,, which spelled out new targets aimed at ending extreme poverty, injustice and inequality, and climate change. Out of the 17 new Global Goals for Sustainable Development, Goal 3 (Good health and well-being), and Goals 5 (Gender Equality) and 10 (Reduce Inequalities), are of particular relevance to the improvement of sexual and reproductive health and rights, and adolescent SRH forms an intrinsic part of the accomplishment of these goals (WHO, 2017).

Furthermore, the *Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030)* was launched, together with the launch of the SDGs in

2015, with its aim being to inspire political leaders and policy-makers to further accelerate their work to improve the health and well-being of women, children and adolescents (Kuruvilla, Bustreo, Kuo, Mishra, Taylor, Fogstad, Gupta, Gilmore, Temmerman & Thomas 2015). The strategy makes a case for women, children and adolescent health to be prioritised by all United Nations (UN) member states, and for governments to invest in interventions that keep women, children and adolescents healthy. A unique feature of the strategy is that, for the first time, the unique nature of adolescent health is acknowledged, including the pivotal role that adolescents themselves can play in driving change towards the accomplishment of SDGs by 2030. Supportive parenting is recognised in this strategy as one of the key intervention packages that can facilitate the achievement of positive sexual and reproductive health outcomes for adolescents, hence this study's special attention was paid to parent-child communication on sexuality as an important aspect that can contribute to the achievement of adolescent health and development.

Flowing from this global commitment to safeguard the sexual and reproductive health of adolescents, several policy instruments at a regional level have been adopted and ratified by the African Union (AU) member countries. In 2006, the African Union Commission's *Continental Policy Framework on Sexual and Reproductive Health and Rights* laid the groundwork for continental, national, and sub regional co-ordination of efforts to mainstream and harmonise SRHR initiatives for adolescents and youth (African Union, 2006). This AU framework document recognised explicitly that neither families nor schools prepare adolescents in terms of their sexual and reproductive health and rights, and further recommended for greater inclusion of families in all efforts to ensure the sexual and reproductive health of adolescents.

The *Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African* (2013), signed by 20 Eastern and Southern African countries, including South Africa, placed adolescent SRH at the

forefront of the agenda of national education and health departments, as an issue that needs urgent redress through concrete actions at policy and implementation level. In this document, parents were mentioned as playing a “primary role in the education and guidance available to adolescents and young people as they transition to becoming young adults” and it was recommended that the design and delivery of adolescent sexual health programmes should include ample participation by communities and families (UNESCO, 2013:4).

In South Africa, the *National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy (2014-2019)* was adopted by the Department of Social Development (DSD) in 2015. This framework provides guidance on action to ensure that adolescent sexual and reproductive health and rights are prioritised, in order to curb unwanted negative SRH outcomes for adolescents in the country. This framework advocates for an approach that involves multiple stakeholders in multiple sectors to address adolescent pregnancy, and states that schools, hospitals, clinics, traditional leaders, community-based organisations, the community, government and the family and caregivers must all be involved in such efforts. The framework further makes recommendations for all sectors involved, including parents, to be capacitated with knowledge and skills to be able to communicate effectively with adolescents on issues of sexuality.

More recently, in 2017, the *National Adolescent and Youth Health Policy (AYHP)* was adopted by the National Department of Health (NDOH), with one of its aims being to guide the designing and implementation of health programmes and services that enhance health and well-being amongst adolescents and youth (NDOH, 2017). In this policy document, the Department of Health (DOH) commits to supporting programmes that work with parents to reduce adolescent pregnancy and to keep adolescents safe in their families and their communities.

This study focuses on the involvement of parents in the fight against early and unintended pregnancies, based on their pivotal role as recognised in the

above-mentioned global, regional, sub-regional as well as national policy and implementation guidelines for adolescent SRH.

Health communication

While policy frameworks are valuable in providing guidelines for action, it still remains an imperative to ensure that they are operationalised through interventions on the ground at various levels. In the field of adolescent sexual and reproductive health, these interventions have taken many forms, some of which include the provision of youth-friendly services at health facilities, and scientific innovations that expand contraceptive options for adolescent girls (UNESCO, 2013).

However, it is generally accepted that linking the domains of health and communication is increasingly becoming recognised as essential for the improvement of personal and public health (Rensburg & Krige, 2011). As such, many interventions that address health issues fall under the category of health communication. Communication has the capability to influence change at the personal, community, and societal levels, and can also influence values (Piotrow, Kincaid, Rimon, Rinehart & Samson, 1997). In relation to health issues, communication plays a critical role in influencing change processes that lead to better health outcomes.

Earlier models of communication that have assumed a linear process whereby someone sends a message to a receiver through a channel have been criticised for their impersonal and one-way flow of messages, where the receiver is assumed to be passive, and difference in contexts and demographics are ignored (Melkote & Steeves, 2001). As Durden and Govender (2012) state, these predominantly Western theories of behaviour change failed to take into account that behaviour change is influenced by a variety of factors that transcend the individual, and which are part of the community and society at large.

As the field of health communication has developed, there has been more emphasis placed on the sharing of information, ideas and emotions whereby

messages are created through an ongoing transactional process between the communication partners involved in the communication process (Rensburg & Krige, 2011). In the field of HIV health communication, McKee *et al*, (2004) have proposed that communication should be strategic, meaning that it should combine various elements, including linkages to other programme elements and level that stimulate positive and measureable behaviour change among the intended audience. Developments in health communication have resulted in a shift in focus from behaviour change communication, which focuses on the individual, to social change communication, which takes into consideration the cultural context of those being targeted in health communication campaigns, and which integrates media, interpersonal communication and advocacy (Govender, 2011).

This study explores parent-child communication as a health communication strategy that is at the interpersonal level between parents and adolescents. The focus on parent-child communication on sexuality is done with an understanding that it should not be a stand-alone strategy, but should be embedded in a broader multi-level intervention aimed at addressing adolescent pregnancy. It is, therefore, important in this review of literature, to provide an overview of other communication efforts that have been, and continue to be implemented, to decrease high levels of adolescent pregnancy.

Communication strategies that have been used to address adolescent SRH at regional level

Efforts to curb adverse sexual and reproductive health outcomes amongst adolescents in Sub-Saharan Africa (SSA) have been many and varied. Whilst some programmes have proven unsuccessful in yielding the desired sexual and reproductive health outcomes in adolescents, the majority of efforts and programmes on Adolescent Sexual and Reproductive Health Education (ASRHE) in the Sub-Saharan African context have yielded positive outcomes (Kalembo, Zgambo & Yukai, 2013).

Examples of strategies that have been employed to achieve positive sexual and reproductive health outcomes for adolescents include peer-led

programmes (Boyer, Sieverding, Siller, Gallaread & Chang, 2017; Cupples, Zukoski & Dierwechter, 2010; Mason-Jones, Mathews & Flisher, 2011; Maticka-Tyandale & Barnett, 2010), school-based education initiatives (Agha & Van Rossem, 2004; Esere, 2008), mass media (Strasburger, 2004; Sznitman, 2011), and community-based initiatives.

In a school-based, peer-led HIV education programme in Zambia (Agha & Van Rossem, 2004), results showed an improvement in attitudes and beliefs concerning condom use and abstinence, while a peer-led ASRHE intervention in Nigeria and Ghana (Brieger, Delano, Lane, Oladepo & Oyediran, 2001) resulted in significant improvements in condom use amongst adolescents, although the same cannot be said for a peer-led ASRHE initiative in South Africa, where results showed no significant differences in condom use, decision-making and age of sexual debut between intervention and control groups (Mason-Jones *et al*, 2011).

Mass mediated ASRHE interventions targeting adolescents have also been implemented in some countries in Sub-Saharan Africa, albeit with limited success. A review of the effectiveness of mass mediated programmes for child survival conducted by Naugle and Hornik (2014), and which included 67 studies of SRH programmes, revealed mixed results, with some showing positive impacts on behaviour, while others showed no effects.

Other community-based initiatives on comprehensive sexuality education, involving young people, health care workers, and parents have been implemented in Zimbabwe and Kenya, and have proven effective in delaying sexual debut, increasing contraception, including condom use and abstinence, and reducing the number of sexual partners amongst intervention groups (Kim *et al*, 2001).

In a study conducted to explore and identify effective methods for delivering ASRHE, 15 studies were reviewed in ten African countries (Kalembo *et al*, 2013). This desktop review exercise revealed that mass media, health facility, school, peer and community-based ASRHE programmes yielded positive

sexual and reproductive health outcomes for adolescents who had been exposed to such programmes (Kalembo *et al*, 2013). However, in the same study, findings showed that adolescents themselves complained about the lack of parental involvement in community-based ASRHE programmes, saying that they found it difficult to communicate what they were learning with their parents.

It is therefore important to point out that parent-child communication on sexuality, as a strategy to address unacceptably high levels of unplanned adolescent pregnancies, is not seen as a stand-alone strategy, but rather as an additional tool that can further add to the arsenal against negative sexual and reproductive health outcomes for adolescents.

Parent-child communication on sexuality

The topic of parent-child communication around issues of sexuality has been the subject of many research studies over the past few years (Frisco, 2005; Pearson, Muller & Frisco, 2006; Phetla *et al*, 2008; Schouten, Van Den Putte, Pasmans & Meeuwesen, 2007). This is because of the acknowledgement amongst practitioners and academics that parents can play an important role in communicating with their children about sexuality, relationships and well-being (UNESCO, 2015).

The body of knowledge on parent-child communication around issues of sexuality is growing globally. There is increasing acknowledgement that parents and family influence play a significant role in the sexual behaviours of adolescents and young people in general (Aspy, Vesely, Oman, Rodine, Marshall & Mcleroy, 2007; Eisenberg, Sieving, Bearinger, Swain & Resnick, 2006; Perrino, Gonzalez-Soldevilla, Pantin & Szapocznik, 2000; Pop & Rusu, 2015). Apart from sexual and reproductive health outcomes, parent-child communication has been shown to influence a variety of adolescent behaviours, including child career development, obesity and many other adolescent educational and health issues (Lindsay, Sussner, Kim & Gortmaker, 2006).

It has been shown that the social environment in which adolescents live and learn has a considerable influence on their transition from adolescence to healthy adulthood, and parents and families are considered a crucial part of this social environment (Dilorio, Pluhar & Belcher, 2003). There is substantial evidence that shows that parents and families play a key role in shaping attitudes, norms and values related to gender roles, sexuality and the status of adolescents and young people in the community (Svanemyr, Amin, Robles & Greene, 2015; UNICEF, 2013).

An evaluation of 44 programmes on parent-child communication on sexuality, delivered in diverse settings, was conducted by Wight and Fullerton (2013). Although limited by the lack of rigorous evaluations in some of the programmes, the findings of this review exercise revealed that targeted programmes with intensive parental involvement can modify adolescents' sexual behaviour. In an evaluation study involving parents who were involved in a parenting programme on sexuality, and a control group (no intervention), Davis, Blitstein, Evans & Kamyab (2010) found that parents who received the parenting intervention were successful in influencing their adolescent children to delay sexual debut. As such, skills training for parents have been identified as important to ensure that sexuality discussions between parents and their adolescent children yield the most positive results (Dilorio *et al*, 2009).

Other factors that influence the success of parent-child communication on sexuality have also been identified, and include communication style, tone, frequency, content, timing, and the age and sex of the adolescent (Eisenberg *et al*, 2006). It has been demonstrated as well that communication on sexuality between parents and their children needs to start before children become sexually active, for it to have a positive impact on outcomes (Bastien *et al*, 2011). Some scholars have also recommended that interventions aimed at assisting parents to initiate and maintain open communication on sexuality with their children should take into account the contextual factors that influence the success or failure of a programme (Jaccard, Dodge & Dittus, 2002).

While evidence is scarce and still emerging, parent-child communication on sexuality in the African context is gaining considerable attention, both in practice and in scholarship (Bhana *et al*, 2004; Phetla *et al*, 2008; Vilanculos & Nduna, 2016). In 2007, the WHO published a report summarising parent-adolescent programmes in developing countries that aim to improve sexual and reproductive health outcomes for adolescents. Eight of the interventions profiled were implemented in African countries, namely, South Africa, Kenya, Zambia, Uganda, Sierra Leone, Malawi, Senegal and Burkina Faso, providing evidence that parent-child communication on sexuality, as a communication strategy, is gaining traction even on the African continent. These were only a few interventions that were featured in this document. Many more interventions have been implemented in many other African countries, including Nigeria, Zimbabwe, Tanzania and South Africa (Bhana *et al*, 2004; Phetla *et al*, 2008).

In addition to interventions on the ground, there is a growing body of scholarly research that is being produced on parent-child communication on sexuality in the African context. Studies exploring perceptions of parents on parent-child communication on sexuality have been conducted in Nigeria, Namibia, South Africa, Kenya, and in many other African countries (see Akinwale *et al*, 2009; Bastien *et al*, 2011; Bello, Fatusi, Adepoju, Maina, Kabiru, Sommer & Mmari, 2017; Bhana *et al*, 2009; Emelumadu, 2014; Hindin & Fatusi, 2009; Kamangu, John & Nyakoki, 2017; Kuo, Atujuna, Mathews, Stein, Hoare, Beardslee, Operario, Cluver & Brown, 2016; Mbugua, 2007; Nambambi & Mufune, 2011; Namisi *et al*, 2009; Phetla *et al*, 2008; Soon, Kaida, Dietrich, Gray & Cescon, 2013; Vilanculos and Nduna, 2017; Wamoyi *et al*, 2010) and many others.

While the positive effect of open parent-child communication about sexual and reproductive health issues has been widely documented in different contexts globally, some studies show no effects on adolescent sexual behaviour as a result of parent-child sexuality communication (Miller, 2002), while others reveal a negative correlation between open parent-child sexuality communication and adolescent sexual and reproductive health outcomes (Bersamin *et al*, 2008). In many cases, this has been attributed to the fact that

constructs used to measure parent-child sexuality communication outcomes are highly varied and crude, making it difficult to capture the exact nature of what parents are saying or doing that makes a difference, as most findings are usually silent on the specific quantity and quality of the communication being evaluated (Hyde *et al*, 2009).

To illustrate this factor, Hyde, Carney, Drennan, Butler, Lohan & Howlett (2013), using a qualitative methodology, conducted interviews with parents in Ireland (32 mothers and 11 fathers) to ascertain the exact nature of what parents convey to their children about safer sex practices. Their findings were that while the majority of parents interviewed professed to be having open communication about safer sex with their children, only a minority reportedly conveyed any messages about contraception and condom use. Messages that parents conveyed to their children were found to be superficial, and were mostly conveyed in a tacit manner through innuendo and intimation. This study cautioned that claims about the effectiveness (or lack thereof) of parent-child communication on sexuality should only be made based on a full understanding of the content of that communication, as well as its frequency.

Adding further complexity to this phenomenon, other research shows that it is the general characteristics of the relationship between parents and children that appears to be more influential on children's sexual decision-making, rather than sex-specific communication. Indeed, evidence has shown that "young people who perceive their parents as warm, caring, interested and responsive...are more likely to postpone sexual behaviour, use contraception if they are sexually active, and have fewer pregnancies" (Wight & Fullerton, 2013:4,5).

The wide range of activities and actions that adolescents may subjectively regard as warm, caring, interested and responsive, however, limits the reliability of this finding (Wight & Fullerton, 2013). Nevertheless, it does raise an important consideration to the discourse on parent-child communication content, that is, is it sex-specific parent-child communication that produces these desirable results or is it general parental connectedness and

supportiveness? In responding to this question, some scholars have suggested that it may be a combination of both factors (sex-focused parenting and generic parenting processes) that lead to positive sexual and reproductive health outcomes for adolescents (Parkes, Henderson, Wight & Nixon, 2011). This further demonstrates the complexity of the subject of parent-child communication, especially with regards to improving adolescent SRH outcomes.

However, despite the many recognised grey areas with regards to this phenomenon, the call for more parental involvement in sexuality education is getting stronger as more and more programmes on parent-child sexuality communication are yielding positive results (WHO, 2007). However, some scholars have stated that researchers must not be discouraged by this but should instead embrace the complexity and avoid premature statements about the effectiveness of parent-based approaches (Jaccard *et al*, 2002).

This study explores the perceptions of parents on parent-child communication on sexuality, and so the subsequent sections of this chapter will explore literature investigating parents' perceptions in various geographical and cultural contexts. Literature that explores cultural and structural barriers and enablers to parent-child communication on sexuality will also be reviewed. This will be done from the global perspective, as well as with particular reference to the African context.

Parents' perceptions of parent-child communication on sexuality – a global perspective

Studies with parents in different parts of the globe have yielded different results in terms of how parents view parent-child communication on sexuality. While many parents believe that it is important to talk to children about issues of sexuality, many don't, due to lack of information and skills (Wilson *et al*, 2010). Some parents also feel restricted not only by knowledge, but by restrictive cultural norms as well (Wamoyi *et al*, 2010). Studies have also found that when parent-child sexuality communication occurs, it is usually on a same-sex basis, is in the form of warnings, threats and physical discipline,

and is almost always triggered by something negative like HIV or teenage pregnancy (Wamoyi *et al*, 2010). Parents have been found to hold conflicting views about the age at which communication should occur with their adolescents, with younger parents preferring to start earlier before the onset of puberty, and older parents believing that they should start after the onset of puberty (Kuo *et al*, 2011; Vilanculos & Nduna, 2017).

There are many studies that have been conducted, particularly in the West and Europe, that have explored parents' perspectives on parent-child communication on sexuality. In a qualitative study, involving focus group discussions with 25 parents, Ballard and Gross (2009) explored United States (US) parents' perceptions on parent-child communication on sexuality. Involving parents of toddlers, and of a relatively higher socio-economic background, Ballard and Gross (2009) explored four aspects related to parents' perceptions, namely; 1) parents' personal experiences of sexuality education with their parents, 2) the current state of sexuality communication that parents were engaging in with their children, 3) the parents' comfort and confidence levels in communicating about issues of sexuality with their children, as well as 4) parents' understanding of the content and timing of sexuality communication with their children.

With regards to parents' personal experiences, parents reported having had no communication with their own parents on sexuality (although this was a motivating factor for most parents to do better with their own children), while some reported having been given books to read, and others being told incorrect information. This finding is similar to findings in other studies where parents report being motivated to initiate discussion with their children on sexuality by the fact that they did not get the same opportunity when they were growing up, and so they want to do things differently (Hyde *et al*, 2009; Nambambi & Mufune, 2011).

The same study referred above also found that current communication by parents is mostly on biological aspects related to anatomy, birth control, and reproduction, with issues of love, dating, gender roles and body image being

rarely discussed, although many wished to be empowered to include this relational aspect as well in their communication with their children. Parents in this study also expressed the desire to be the primary sources of information and guidance in relation to issues of sexuality with their children, a sentiment also expressed by parents in other studies (Hyde *et al*, 2009; Nambambi & Mufune, 2011; Turner & Sanders, 2006).

This study was, however, limited by its narrow focus on parents belonging to a higher socio-economic demographic class, and that they were all parents of toddlers and not adolescents. With parents having been selected through random sampling, the findings of this study cannot be generalised widely to other sub-populations of parents, especially in the African context.

In a study conducted with Irish parents from varying geographical locations, 39 interviews were conducted with both male and female parents to ascertain, amongst other factors, their current practices on parent-child communication on sexuality (Hyde *et al*, 2009). Parents were selected through a combination of purposive and snowball sampling, as the study sought to explore age differences and socio-demographic factors related to parent-child communication. Parents' accounts in this study revealed that communication on sexuality was mostly child-initiated in the form of questions posed to the parents; was intermittent, with parents using opportunistic 'teachable' moments, and was mostly sparked by some 'wake-up call' (an event or occurrence that revealed some level of risky exposure to their child). Many parents reported having received 'the talk' from their own parents, but rarely used this strategy with their own children. Whilst this was groundbreaking research from the Irish context, which provided insights on parents' approaches to educating their pre-adolescent and adolescent children about sexuality, its results cannot be generalised to other contexts, especially the African context.

As already stated earlier, the majority of studies that explore parent's perceptions of parent-child communication are in Western contexts. There is a gap in knowledge in terms of perceptions of parents in the African context,

and more specifically in the South African context. Such a study is therefore necessary within the South African cultural context, especially in the light of teenage pregnancy statistics that are yet to be abated, and an HIV epidemic that threatens to adversely affect the health of the nation at large.

Parents' perceptions of parent-child communication on sexuality in the African context

While there is a plethora of studies from other parts of the globe, studies on parent-child communication with adolescents on sexuality remains scarce for the African, and more specifically the South African cultural context. Research that applies to the African cultural context on parent-child communication on sexuality is growing, but still leaves many gaps in knowledge. However, it is important to review literature produced from the African context, in order to establish the current discourses around parent-child communication on sexuality within this particular context.

A review of literature on parent-child communication on sexuality, including HIV and Acquired Immuno-Deficiency Syndrome (AIDS) in sub-Saharan Africa was conducted between 1980 and 2011, with three of the studies examined being from South Africa (Bastien *et al*, 2011). The frequency, content, style, tone of discussions, preferences, associations and barriers to sexuality communication were investigated. In addition, studies that examined behavioural determinants of parent-child sexuality communication, as well as intervention studies aimed at improving parent-child sexuality communication, were examined.

The overall findings of this review exercise revealed that parent-child sexuality communication tended to be authoritative and unidirectional, with vague warnings, instead of direct, open communication (Bastien *et al*, 2011). Findings from the same study also revealed that the extended family also played an important role in the education of adolescents on issues of sexuality, which is something that had not been observed in more Western cultural contexts. This was a literature review of a range of studies from different countries in Sub-Saharan Africa, so it served to provide a picture of

the status quo with regards to parent-child communication on sexuality. There was no attempt in this study to further investigate parents' ideas for future programming, especially taking the cultural context into consideration.

In Namibia, a qualitative study was conducted, where interviews were conducted with children (male and female), mothers and fathers to establish the nature of sexuality communication that was taking place between parents and their children between the ages of 14 and 24 (Nambambi & Mufune, 2011). Reports from both parents and children revealed that communication was very limited. Where it happened, it was in the form of information giving and warnings, and there were rarely any discussions around such topics. Both parents and their children reported that they were forced by HIV risks to engage in such communication.

As already discovered in other studies outside of the African continent (Ballard & Gross, 2009; Hyde *et al*, 2009) young people interviewed in this study mostly preferred to talk with mothers, as opposed to fathers when it comes to communicating on issues of sexuality. The study also found that mothers find it easier to talk with girls than with boys, although they waited too late (after first menstruation) to initiate these discussions. Although parents in this study felt it was better for parents to educate their own children on these issues, results showed that they were conveying mixed messages for girls and boys, where sexual activity was portrayed as dangerous for girls, but portrayed as an adventure for boys. This study explored the current status of parent-child communication on sexuality with Namibian parents, and did not make an attempt to investigate future directions for programming, from the parents' perspective. As such, the study does not frame parents as active agents who can provide their own solutions to future programming, based on their cultural backgrounds.

Various other studies that have been conducted in the African context have yielded similar results in terms of parents' current communication with their children on sexuality. In a study conducted in Dar es Salaam (Tanzania) and Cape Town (South Africa), 14,994 adolescents completed a baseline survey

questionnaire on their communication with parents on issues of sexuality (Namisi *et al*, 2009). Results of this study revealed that a substantial proportion of adolescents reported not communicating with their parents about issues of sexuality, including HIV/AIDS, abstinence or condoms. This finding was similar across all socio-demographic sub-groups, although girls in Dar es Salaam reported the most silence from adults about issues of sexuality. In the few cases where parent-child communication on sexuality took place, it was related to parents' higher socio-economic status.

In a study in Nigeria, it was found that many parents believe that communication on sexuality will lead to early initiation of sexual activity, and so they opt not have these discussions with their adolescent children (Akinwale *et al*, 2009). The same study found that younger parents perceived parent-child sexuality communication more important than their older counterparts, resulting in younger parents engaging in sexuality communication and older parents not communicating with their adolescent children. Another study in South Africa also compared younger and older parents' perceptions of parent-child communication on sexuality in selected sites, including KwaZulu-Natal (Vilanculos & Nduna, 2017). The findings from this study revealed that younger parents preferred to start sexuality communication with their adolescents earlier (before the onset of puberty), while older parents felt that the onset of puberty was the right time to start communication. This study concluded that adolescents living with older parents, including grandmothers, may be disadvantaged by this factor, as they may get informed about sexuality much later than adolescents living with younger parents. This age dimension will be further investigated in this study.

More recently, another study found that mothers of adolescents in under-resourced slums of Nigeria and Kenya primarily advised their adolescent children of the dangers of sexual relationships, using scare tactics, and emphasizing the negative consequences of sexual activity such as pregnancy and STIs (Bello *et al*, 2017). In contrast to other studies that have been conducted in the US, United Kingdom (UK), Ireland, and other contexts globally, there appears to be a marked resistance or reluctance to engaging in

communication on sexuality by parents in most African contexts. It is therefore important to explore factors that parents see as barriers to initiating and maintaining open parent-child communication on sexuality with adolescents.

Existing literature does not only provide insight into barriers, but also on factors that parents view as enablers towards communicating with their adolescent children on sexuality. As this study is framed within the Culture-Centred Approach (CCA) to health communication, which puts emphasis on community voices being amplified, an investigation into perceived barriers and enablers allows the researcher to provide space for the articulation of challenges and opportunities, from the cultural perspective of study participants.

Barriers to parent-child communication on sexuality

Studies around the globe reveal that parents in general experience some challenges when it comes to engaging in discussions on sexuality with their children. Most of the barriers expressed by parents tend to be similar across different contexts. The most common barriers that have been cited by parents are embarrassment to talk about issues of sexuality with children, as well as lack of knowledge on how to start such conversations (Ballard & Gross, 2009; Kamangu *et al*, 2017; Soon *et al*, 2003; Mbugua, 2007; Weekes, Haas & Gosselin, 2013; Wilson, Dalberth, Koo & Gard, 2010).

Other barriers that have been cited, and which seem to be experienced equally by parents everywhere are; (1) the concern that talking to children about sexuality may encourage early sexual debut (Hyde *et al*, 2013), (2) parents being complacent due to the knowledge that their children are receiving sexuality education in schools (Mbugua, 2007; Nambambi & Mufune, 2011), as well as children themselves portraying a 'know-it-all' attitude, which parents found hard to counteract (Bastien *et al*, 2011; Phetla *et al*, 2008).

The above barriers have been found consistently in studies from Western and African contexts. However, parents from the African cultural context report

other barriers that have not been reported in other contexts. A study in Kenya found that most educated mothers were inhibited by socio-cultural and religious inhibitions from providing meaningful sex-education to their pre-adolescent and adolescent daughters (Mbugua, 2007). In many other instances, parents and children have cited cultural and institutional barriers as obstacles in opening communication between parents and their children (Akinwale *et al*, 2009; Kamangu, 2017; Mbugua, 2007).

A study involving focus group discussions with parents in Kenya, Uganda, Rwanda and Tanzania also revealed that religious beliefs play a big role in discouraging parents from talking to their children about issues of sexuality (Kamangu, 2017). Parents that were part of this study, whether Christian or Moslem, frequently referred to the use of condoms and contraception as sinful, and therefore something that they discouraged their children from using, let alone talk about. Findings similar to the ones by Kamangu (2017) were obtained by Namisi *et al*, (2009), Mbugua (2007), and Wamoyi *et al*, (2010).

Some parents who do have open parent-child sexuality communication with their adolescent children wait till they believe that their child is in a romantic relationship before they initiate such conversations, and thereby miss opportunities to influence their children's sexuality by waiting till it is too late (Eisenberg *et al*, 2005). Where parents are more receptive to starting parent-child sexuality communication, they have expressed that they need a system of support, training that includes not just what, but also how and when to talk to their children (Ballard & Gross, 2009; Wilson *et al*, 2010). Some parents have also expressed the need to have multiple strategies that they can use to initiate and maintain healthy sexuality communication with their adolescent children, as well as a strong community support mechanism on which they can rely when they run into difficulties (Bhana *et al*, 2009).

Enabling factors to parent-child communication on sexuality

When asked, in various studies, about the different factors that would enable them to initiate parent-child communication on sexuality, parents have voiced

various strategies and ideas. Some parents have expressed an interest in a more structured and formal approach involving regular educational sessions that are conducted face-to-face, and which may involve a combination of the internet, books, other parents, hotlines, churches, health-care facilities and schools (Ballard & Gross, 2009).

Parents have also indicated they need motivation and strategies that will aid in effective communication with their adolescents, as well as family interventions that focus on positive parenting and that facilitate family bonding (Kuo *et al*, 2016; Pop & Rusu, 2015).

Evaluations of interventions aimed at improving parent-child communication on sexuality have yielded some promising results. Some studies have provided glimpses into what may enable parents to communicate with their children on issues of sexuality. Most of the evidence in this regard comes from evaluations of programmes that have been implemented with the aim being to empower parents to initiate such discussions.

In Limpopo Province in South Africa, Phetla and colleagues (2008) implemented a programme for parents called *Sisters for Life*, which sought to encourage parents to challenge barriers to engaging with young people about sex and sexual health. An evaluation of this programme revealed that the curriculum that the women were taken through helped to improve parent-child communication on sexuality. The intervention is said to have improved motivation and communication skills in parents, resulting in parents conveying messages that were clearer, using a wider range of strategies. The intervention is also reported to have improved parents' communication tone and style.

This points to the fact that when parents are assisted through formal sessions over a prolonged period of time, inhibitions to communicating with their children on sexuality are significantly reduced. A finding similar to this one was also made with a cohort of African American parents who were also taken through a structured programme (Weekes *et al*, 2014). Parents are

reported to have improved their self-efficacy to initiate parent-child communication as a result of a multi-media intervention that involved the use of audiotapes, supported with instruction booklets for parents. The use of a multi-media package in this study improved African American mothers' confidence in initiating sexuality communication with their adolescent sons, indicating some promise for future interventions to be able to transcend the gender divide in parent-child dyads.

Another programme that provides promising evidence for success in such programmes is the Collaborative HIV/AIDS and Adolescent Mental Health Programme (CHAMP), which was piloted in rural and semi-rural areas of KwaZulu-Natal, South Africa in 2004 (Bhana *et al*, 2004). CHAMP was originally developed in the United States, and subsequently adapted for use in Trinidad and Tobago, New York, Chicago and subsequently South Africa, among low-income families.

This programme was aimed at preventing HIV infections in youth through promoting resiliency in adolescents and their families. Whilst parents initially found it difficult to talk with their adolescent children about HIV/AIDS and other sexuality issues, exposure to the programme over time resulted in improved parents' confidence in communicating about issues of sexuality with their children. The CHAMP South Africa (SA) intervention was also unique in that it did not only target changes at an individual level, but it also adopted a multi-level focus that sought to influence individual processes at a personal level, interpersonal and family processes, as well as community-level factors. Although the programme was imported from the US, its adaptation process involved parents influencing the activities that were part of the manual, to ensure that they addressed their cultural and structural context, and hence the programme's success can be attributed to this factor as well. The participatory nature of this programme, especially to ensure cultural relevance for the participants, is something that the Culture-Centred Approach to health communication promotes, to ensure optimal outcomes for the project participants.

Conclusion

This chapter has highlighted the extent to which unintended adolescent pregnancies are a challenge globally, regionally and locally in South Africa. Health communication strategies that have been employed in addressing this challenge have been explored, including parent-child communication on sexuality. The chapter has presented a global overview of parent-child communication on sexuality, and has highlighted parents' perceptions in both Western and African contexts. The literature reviewed shows that the concept of parent-child communication on sexuality is receiving increased attention in the African context, with some studies showing positive impacts on adolescent sexual and reproductive health outcomes. However, the literature has also shown that parent-child communication on sexuality presents some challenges for parents and adolescents. This study explores parents' perceptions of the concept of parent-child communication on sexuality from the cultural perspectives of selected groups of parents in eThekweni Municipality in KwaZulu-Natal.

The next chapter will provide an outline of the theoretical framework that underpins this study.

CHAPTER THREE - THEORETICAL FRAMEWORK

Introduction

The Culture-Centred Approach to health communication, as put forward by Mohan Dutta (2008) is the theoretical lens through which this study is framed. The key constructs of the Culture-Centred Approach to health communication; culture, structure and agency, lend themselves well to the exploration of the key questions that are asked in this study. In seeking to understand parents' perceptions of parent-child communication on sexuality, this study explores the nature of conversations that parents are having with their adolescent children on sexuality, the cultural and structural factors parents perceive as promoting or prohibiting their ability to initiate and maintain effective parent-child communication on sexuality, and the enabling factors that parents perceive as important for them to be able to initiate and maintain effective parent-child communication on sexuality.

As will be expounded upon further in this chapter, Dutta's (2008) Culture-Centred Approach to health communication allows the researcher to be able to engage in a dialogical process with the research participants so that the research questions are answered in a way that not only deepens insight for the health communication field, but that also results in research participants being the agents of change in parent-child communication programmes on sexuality that may be designed for their benefit.

Parent-child communication on sexuality, as a concept, is not seen as a stand-alone intervention that has the ability to singularly impact sexual and reproductive health outcomes for adolescents. Rather, it is seen as an integral part of a holistic, multi-level strategy that tackles both proximal and distal factors that influence adolescent sexual and reproductive health. As a result, Kincaid *et al*'s (2007) Social Ecology Model of Communication and Health Behaviour (SEMCHB) is used in this chapter to provide the conceptual frame for parent-child communication on sexuality, as will be further explained in the sections that follow.

The Social Ecology Model for Communication and Health Behaviour

The quest to understand human behaviour and how it can be influenced has been at the heart of scholarship and theorising for many decades. Having their roots in the field of psychology, several theories have been put forward by theorists to try and explain various aspects of human behaviour.

The term ecology refers to the study of the relationships between organisms and their environment (Stokols, 1996). As such, the Social Ecology Model (SEM) is founded on the basic premise that human behaviour is influenced by the social, institutional and cultural contexts surrounding people (Stokols, 1996).

It has been stated that the core concept of an ecological model is that behaviour has multiple levels of influences, often including intrapersonal, interpersonal, organizational, community, physical environmental, and policy (Sallis *et al*, 2015). Social ecology theorising, therefore, allows the researcher to focus beyond just the individual in order to understand human behaviour, but to also explore “the social and physical environments that constitute people’s habitats” (Oishi & Graham, 2010:356). Similarly in this study, while it is the human behaviour of adolescent sexual behaviour that is targeted for change, it is the interest of the researcher to explore the interpersonal relations with parents, and how these do or can influence the sexual behaviour of adolescents.

Historical background of ecological models

The origins of social ecology scholarship can be traced back to the works of several scholars in the behavioural and social sciences. According to Sallis *et al* (2015), earlier models were designed for application to behaviours in broad terms, and examples of these are Kurt Lewin’s Ecological Psychology, Roger Barker’s Environmental Psychology, Rudolph Moos’ Social Ecology, Bronfenbrenner’s Systems Theory, and Glass and Matthew’s Eco-social Model. A similar thread running through all these earlier models is their focus on explaining health behaviours, as opposed to later models that are

specifically designed to guide behavioural interventions (Sallis *et al*, 2015).

Later models that were developed from the 1980's onwards were created for application to health behaviours and health promotion (*ibid*), with their specific focus being on guiding behavioural interventions. A common argument running through recent ecological models is that health-related behaviours are influenced by multiple factors including intrapersonal, interpersonal, organisational, community, physical environment and public policy (Sallis *et al*, 2015). Ecological models introduce a shift from the persuasion-based approach, which is focused on creating messages that are designed to persuade the individual to engage in a behaviour (Dutta, 2008), to an approach which focuses attention on the social and physical contexts that influence behaviour as well as the external factors shaping their agency.

Scholars who have contributed to the development of these social ecology models, albeit with differing emphases, are Skinner (1953), Bandura (1989), McLeroy *et al*, (1988), Stokols (1992, 1996), Flay, Snyder and Petraitis (2009), Glanz, Rimer and Viswanath (2008) and others.

While Skinner's Operant Learning Theory pointed to environmental cues as controllers of behaviour (Skinner, 1953), Bandura's Social Learning and Social Cognitive Theories emphasised the role of personal, environmental, as well as social influences as having an impact on behaviour (Bandura, 1989). Both theorists, however, did not address the role of physical, community and organisational environments in influencing health-related behaviours.

Later, McLeroy *et al*, (1988) pointed to five sources of influence on health behaviours, namely intrapersonal factors, interpersonal processes, institutional factors, community factors, and public policy, arguing that it is these factors that determine individual health behaviour. In their Theory of Triadic Influence, however, Flay, Snyder and Petraitis (2009) asserted that it is only three streams of influence that affect health behaviours, namely intrapersonal, social and socio-cultural influences. The Structural-Ecological Model proposed by Cohen, Scribner and Farley (2000), in turn, identified four

categories of structural influences that have an influence on behaviour, namely; (1) availability of protective or harmful consumer products, (2) physical structures, (3) social structures and policies, and (4) media and cultural messages.

A further proponent of SEM was Stokols (1996), who proposed a model based on four main assumptions, namely; (1) health behaviour is influenced by physical environments, social environments, and personal attributes; (2) environments are multi-dimensional, such as social or physical, actual or perceived, discrete attributes or constructs; (3) human-environment interactions occur at varying levels of aggregation; and (4) people influence their settings, and the changed settings then influence health behaviours.

A common thread of argument running through all the above proponents of the Social Ecological Model is the criticism of behavioural change models which put emphasis on active interventions that require voluntary and sustained effort by the targeted audience (often individuals), in order to achieve desired health outcomes (Stokols, 1996). Such efforts are said to be more difficult to maintain over extended periods of time, thus resulting in short-lived results.

While the emphases are different in these various ecological models, Sallis *et al*, (2008) maintain that they are all based on four basic principles; (1) multiple levels of factors influence health behaviours, as opposed to just one or two, (2) influences interact across different levels, (3) multi-level influences should be most effective in changing behaviour, and (4) ecological models are most powerful when they are behaviour specific.

In the publication *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*, Chandra-Mouli *et al*, (2013) state that early pregnancy and poor reproductive outcomes amongst adolescents are influenced by a web of micro and macro level factors that include family and community norms, traditions, and economic circumstances. In addition, they state, policy and regulatory

frameworks also play a part in determining the choices that adolescents make in relation to their sexual and reproductive health. They therefore recommend that actions aimed at improving the health of adolescents must be taken at each of the levels stated above by different sectors. The UNFPA concurs with this recommendation by their assertion that successful programmes aimed at preventing adolescent pregnancy are the ones that combine a variety of integrated and multi-sectoral responses targeting young people and their families (Laoiza & Liang, 2013).

This study applies the SEMCHB as advanced by Kincaid *et al*, (2007), to propose that similarly, adolescents' sexual health behaviour and development is influenced by a myriad of factors, including interpersonal communication with their parents. According to Storey and Figueroa (2012:72), the SEMCHB "implies that if individual change is facilitated and supported by social changes at higher levels, it is more likely to be self-sustaining". In turn, as Sallis *et al*, (2015) assert, efforts to influence their sexual behaviour, whether to change risky behaviours or to support healthy behaviours, must be based on an understanding that health communication interventions need to be implemented across multiple levels, because a single-level intervention is less likely to yield the desired outcomes.

This study recognises the need for programmes targeting adolescent sexual and reproductive health to be designed holistically, and in a manner that takes cognisance of the multi-level factors that influence adolescent sexual and reproductive health outcomes. In this study, parent-child communication on sexuality is recognised not as an isolated strategy that is a magic bullet, which can singularly bring about improved sexual and reproductive health outcomes for adolescents. Instead, it is seen as a strategy that should form part of a multi-level response, which includes interventions at the macro and micro levels of *Society*, *Community*, *Social Networks* and *Individual*, as illustrated in Figure 3.1 below.

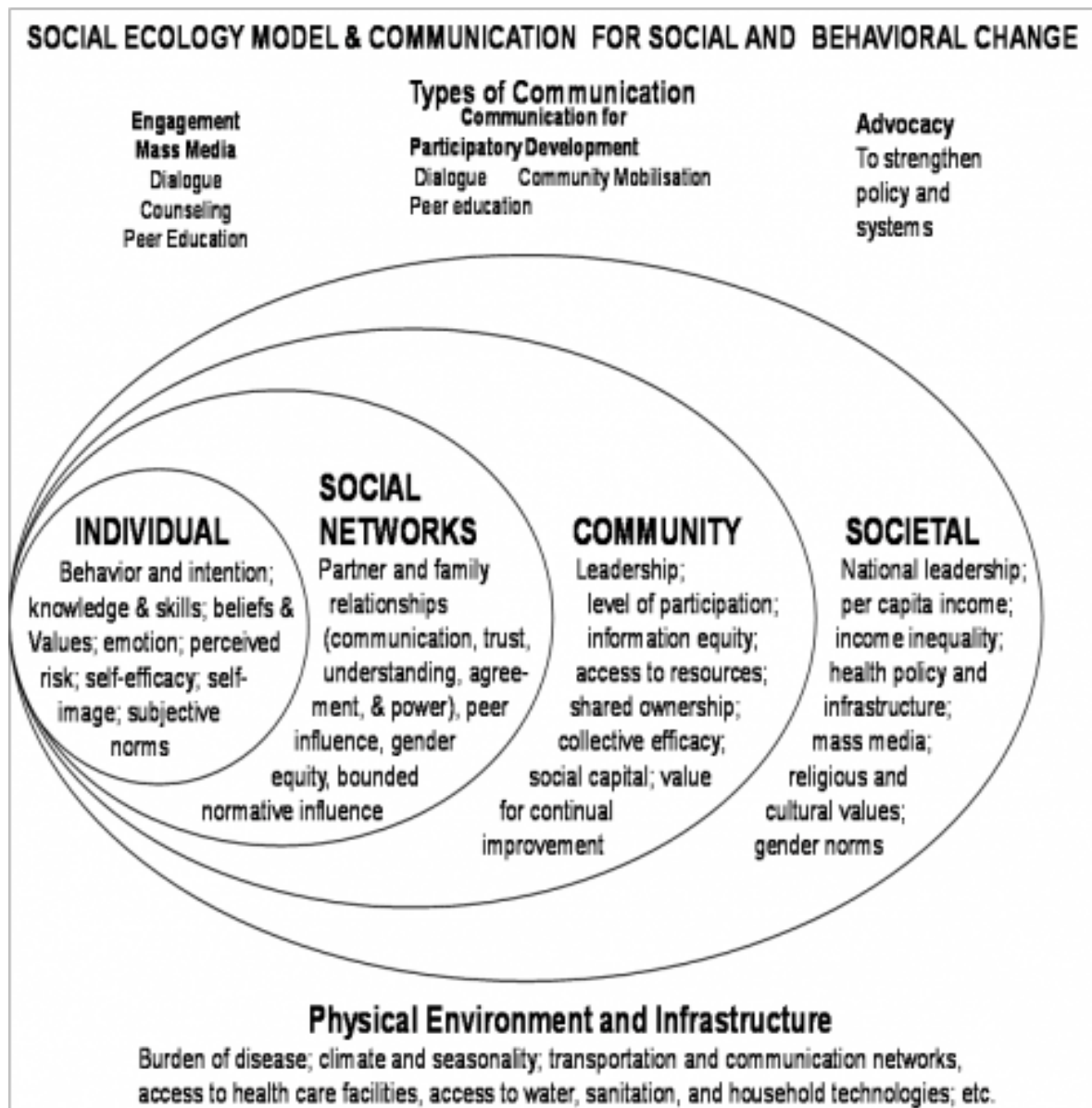


Figure 3.1 – The Social Ecology Model of Communication and Health Behaviour (Kincaid et al, 2007)

In South Africa, and in various other contexts worldwide, there are concerted efforts to ensure that health communication interventions are designed within a Social Ecology Framework. The *South African National Adolescent Sexual and Reproductive Health and Rights Strategy's (2014-2019)* five key priority areas aimed at addressing the reproductive health care for adolescents are evidence of this concerted effort to ensure a multi-level response. The five key priority identified are the following:

Priority 1 – Increased coordination, collaboration, information and knowledge sharing on adolescent sexual and reproductive health and

rights (ASRH&R) activities amongst stakeholders;

Priority 2 – Developing innovative approaches to comprehensive SRHR information, education and counselling for adolescents;

Priority 3 - Strengthening ASRH&R service delivery and support on various health concerns;

Priority 4 – Creating effective community supportive networks for adolescents; and

Priority 5 – Formulating evidence based revisions of legislation, policies, strategies and guidelines on ASRH&R.

For each priority defined, there are accompanying objectives that must be fulfilled by government departments, civil society and development partners. Priority 4 has the following objectives:

- a) To strengthen and scale up community networks aimed at supporting adolescents;*
- b) To secure active buy-in and participation by relevant stakeholders;*
- c) To capacitate parents, caregivers, religious and traditional leaders, municipal councillors, school governing bodies, youth forums, parents of youth living with disability;*
- d) To capacitate parents and caregivers, etc. of adolescents with disabilities on dealing with reproductive health functions and rights (especially men);*
- e) To generate interest and involvement of young male adolescents (especially out of school) in sexual and reproductive health rights (SRHR) programming*

Of interest to this study are objectives c) and d), which refer to the need for the involvement of parents in efforts to improve outcomes for the sexual and reproductive health of adolescents. As indicated earlier in the Literature Review chapter, while there has been many programmes implemented at the different levels proposed by the SEMCHB, there is a scarcity of programmes that target parents, as important role-players in the sexual and reproductive

health development of their adolescent children. Therefore, parent-child communication on sexuality in this study is explored as part of a broader strategy aimed at improving the sexual and reproductive health outcomes for adolescents.

Parent-child communication on sexuality is situated within the Social Networks level, and explores the role of the family in communicating health messages that may lead to decreased levels of adolescent pregnancy.

Limitations of Social Ecology Models

While Social Ecology Models have been central to many health promotion and communication programmes for many decades, they have a number of weaknesses. According to Sallis *et al*, (2015), some of these weaknesses are:

- a) Their inability to specify the most significant influence out of all the multi-level influences identified. This poses a challenge for those working with ecological models to develop more sophisticated operational models that can provide useful guidance for interventions;
- b) Social Ecology Models provide broad perspectives and fail to provide specific guidance about how they can be used to improve research or interventions;
- c) A methodological criticism of Social Ecological Models is that they propose complex interactions of personal, social, community and societal characteristics that are challenging to design and conduct in controlled experiments. This, however, can be mitigated through rigorous analytical strategies for evaluation of interventions.

Stokols (1996), further adds that some limitations of social ecology models are that:

- d) They require integration of knowledge from several different disciplines, which can prove to be cumbersome;
- e) The over-inclusiveness of Social Ecology Models does not assist researchers in targeting selected variables for study. Instead, they

make the process of evaluating the efficacy of programmes too cumbersome as there are too many levels and variables to consider.

However Social Ecology Models take into account the more distal and immediate environments in explaining factors that impact on human behaviour. This makes them more amenable to providing opportunities for interventions that address these multi-level factors, while also putting emphasis on the active role that individuals and groups can play in modifying their own health behaviour.

In this study, the application of the SEMCHB, as a conceptual frame helps to locate the concept of parent-child communication on sexuality within a broader and holistic framework of multi-level responses that recognise the influence of cultural and structural factors that impact on adolescent sexuality. At the same time, the SEMCHB helps to locate parent-child communication on sexuality at the social networks level of health communication, within this broader framework.

The Culture-Centred Approach to health communication, allows the researcher to further explore interpersonal communication between parents and their adolescent children. Culture-centred theorising allows the researcher to target this selected aspect by opening up an opportunity for parents' voices to be heard, so that they, in turn, may inform programming on interventions targeted at them with regards to their supportive role in the sexual and reproductive health of their adolescent children.

The Culture-Centred Approach to health communication

The Culture-Centred Approach to health communication draws upon the disciplines of critical theory, cultural studies, postcolonial studies and subaltern studies (Dutta-Bergman, 2005). According to Fuchs (2015:1), critical theory is “an approach that studies society in a dialectical way by analysing political economy, domination, exploitation, and ideologies”. The concepts of power, ideology, hegemony and control that underpin culture-centred health communication scholarship are drawn from critical theory, with added

emphasis on “the social constructions of knowledge and practices” (Dutta, 2011:10).

Cultural studies is aligned with critical theory in that it maintains a focus on power structures and how they are maintained within the social discourse. The CCA then draws upon cultural studies scholarship “with its emphasis on the social constructions of discourse and on the culturally situated nature of health narratives” (ibid).

Postcolonial theory is said to “offer an antithesis to European superiority as embedded in colonial violence, socio-political domination, economic exploitation, and racism” (Kubota & Miller, 2017:10). Culture-centred health communication scholarship explores the “dichotomies of the First and Third World, the North and the South...to see how these dichotomies play out in who gets to decide the health agendas” and further questions the “values underlying this dichotomy...” (Dutta, 2011:11).

Subaltern means of lower rank, but Spivak has widened its scope and attributed the term to the literature of marginality and suppressed groups (Spivak, 2005). The essence of subaltern studies is the questioning of the absence of the voices of marginalised communities in development discourse (Guha, 2001). The CCA interrogates this absence of the subaltern voice by creating “discursive openings for co-constructing narratives of health through dialogue with subaltern communities” (Dutta, 2011: 12).

Characteristics of the Culture-Centred Approach

The CCA “highlights the agency of cultural participants and their ability to frame communication strategies” (Basu & Dutta, 2009:89). The emphasis is placed on “creating opportunities for dialogue that brings out meanings of health, articulated through the voices of cultural communities” (Dutta, 2011:3). In other words, dialogue with participants is key in understanding the health issues that the community faces. Such dialogue is also necessary in informing health communication strategies that are undertaken to influence behaviour and social change. The focus shifts from the researcher and his or her

agenda, and opportunities are provided for problems to be “configured and re-configured”, and for solutions to be “generated based on the needs of the community as defined by community members” (Dutta-Bergman, 2005:116). In this study the researcher is conscious of the opportunity that voice and dialogue with participants offers for a “discursive opening for creating spaces for social change”, where parents can inform the nature and type of parent-child sexuality communication interventions (Dutta, 2011:169).

The concepts of power, ideology, hegemony and control assume a central focus in culture-centred theorising. Dutta (2011) argues that dominant social actors in any given society use power to control the social, cultural and communicative practices of marginalised communities, and that this exercise of power is maintained without coercion, and refers to this as ‘hegemony’. In the field of health communication, this non-coercive control is evident in ‘top-down’ policies and programmes that are conceptualised and designed without the meaningful involvement of marginalised communities that they target. Engaging in dialogue with parents in this study to understand their perceptions on parent-child communication is therefore a “disruptive” exercise that aims to give a voice to study participants, while at the same time challenging the existing hegemonic structures that are in charge of policy and programme development.

The Culture-Centred Approach to health communication further places importance on culture, structure and agency as entry points for social change (Dutta, 2011). At the structural level, it is important to find out what factors promote or inhibit parent-child sexuality communication. Beyond this, however, it is important for participants’ voices to be heard in terms of possible strategies and solutions to promoting effective parent-child sexuality communication. Issues of culture are also explored in terms of the overall sample of *IsiZulu* speaking parents, and also with the aim of discovering if there are any similarities or differences between rural and urban, older and younger parents identified as participants for this study.

It is necessary to also interrogate participants' agency in initiating and maintaining parent-child sexuality communication. As Dutta argues, "in creating subaltern entry points for transformative politics, culture-centred theorising is attentive to the multiple counter-hegemonies and interplays of power as the local engages with the global" (Dutta, 2011:54). In this study, the interest is on how the local (parents) engages with the global concepts of parent-child sexuality communication.

Culture

Culture, as a concept, has been defined and redefined by theorists many times. It is a term that has proved to be "difficult to deal with", and which "defies precise definition due to its complexity, variability and elusiveness" (Embong, 2011:11). In their critique of theories and models applied to HIV/AIDS prevention programmes, Airhihenbuwa, Makinwa and Obregon (2000:11) argue that some scholars have tended to view culture as "what society evolves from in the process of development – a proxy for modernization". This understanding is said to advance a notion that "traditional culture" is something to be overcome in development, and replaced with "modernity". They instead call for an understanding of culture which means "drawing from the potentiating possibilities of a hybrid of traditional and modern culture", and advocate for a process whereby "traditional cultures" do not have to succumb to "development" and "modernity", but "engage them in a constant relationship whereby the resulting hybrid communities can emerge with possibilities for improving conditions of life, whether it is HIV/AIDS prevention or community development" (Ibid: 13).

According to Airhihenbuwa *et al*, (2000:106), culture is seen not as something static and unchanging, but rather as a "collective consciousness of a people often shaped by a shared history, language and psychology". Casimir (1991:230) further defines culture as "common...value-based interpretations, artefacts, organisational forms, and practices of a group of human beings related to a specific environment". In addition, Dutta defines the concept of culture as "the local contexts within which health meanings are constituted and negotiated" (Dutta, 2008:7).

In this study, it is a combination of the above three definitions of culture that is adopted. The differentiation that is made between rural and urban parents, as well as between younger and older parents is based on the assumption that these groupings share some level of 'collective consciousness' that stems from their collective history, language and environment. Furthermore, their perceptions of parent-child communication on sexuality and the meanings that they ascribe to it may be informed by some value-based interpretations, which are informed by their collective history and local contexts.

The dynamic nature of culture is also explored in order to understand the continually shifting cultural meanings that the study participants ascribe to their roles as parents. The comparison between younger and older parents is aimed at exploring if meanings ascribed to the concept of parents talking to their children about issues of sexuality are the same across time, or if there are differences that may yield new insights for programme planners.

According to the Culture-Centred Approach, culture is explored for its value in providing a "communicative framework for health meanings" (Dutta, 2008:3). As such, this research seeks to investigate the meanings that parents attach to the concept of parent-child communication itself, and what implications this may have for programme planners. In order to do this effectively, it is important to consider culture-based perceptions of study participants on the concept of parent-child communication on sexuality, particularly within the *Zulu* cultural context.

Parenting in the African cultural context

It has been asserted that parents' thoughts and actions related to child-rearing are culturally determined (Rubin & Chung, 2013). Indeed some have concurred, stating that "central to every concept of culture is the expectation that different peoples possess different beliefs and behave in different ways with respect to their parenting" (Bornstein & Chaldeah, 2006:15). Several other researchers who have studied the cultural influences on parenting practices echo this sentiment, and further assert that parents have already-

assimilated beliefs and views about cultural expectations of their role as parents in their children's lives (Bornstein, Tal & Tammis-Lemonda, 1991; Mbugua, 2007). This implies that researchers and development workers cannot generalise their own culture-specific ways of understanding to other cultures when developing programmes targeting parents on parent-child communication about sexuality.

In the African context in particular, Kayongo-Male and Onyango (1984), state that the traditional African family was for centuries characterised by the presence of a large number of socialisation agents that included parents, older siblings, aunts, grandparents, cousins and uncles. Education on sexuality was traditionally not the speciality of parents, but the responsibility of other family members, and was usually done along gender lines. This can be said broadly of most African communities. In the South African *Zulu* context, similarly, everything pertaining to sex and sexuality was not taught by parents, but was left largely in the hands of boys and girls who were somewhat older than the rest and who had already gone through that developmental stage and had been taught by older peers themselves (Delius & Glaser, 2002).

Amaqhikiza were older and more mature women who were not yet married, and who not only educated younger girls on matters of sexuality, but also looked after them, assuming a high level of responsibility for their conduct, including when young girls decided to start relationships (Buthelezi, 2004; Gumede, 1978; Hunter, 2004). Boys would similarly have a leader called *Insizwa*, who would be responsible for educating boys, as well as constantly reminding them of the limitations that they had in relations with members of the opposite sex (Delius & Glaser, 2002). This was not particular to *Zulus* only, but was practised by other South African tribes such as the *Pedi* and the *Xhosas* (ibid). As a result of the above discussions of a sexual nature between parents and their children remained a taboo. According to Mbugua (2007), these traditional taboos that hinder parents from talking to their children about sexuality are not unique to any one society, but are common amongst many societies in Sub-Saharan Africa.

This study is therefore foregrounded against this background, where it can be expected that parents may not perceive communication on sexuality as their speciality, due to such cultural influences. It is important, therefore, to investigate parents' perceptions of parent-child communication from a cultural perspective, in order to understand their own perceptions of their role as parents in the education of their children on sexuality. According to Dutta (2008:260), culture-centred theorising seeks to distance itself from "the logic of the rational scientific discourse that dominates much of the health communication scholarship (that) is based on the universal appeal of the science and of the tools of modernity". As such, while this study recognises the gains that parent-child sexuality communication has yielded in many Western contexts, this 'solution' needs to be questioned and brought under scrutiny from the perspective of the parents' cultural understanding of their own role in the education of their children on sexuality.

However, we know that culture is not static, but is both dynamic and adaptive (Kreuter & McClure, 2004). This is an argument that is further supported by Bandura (2006:174) when he states that "cultures are dynamic and internally diverse systems, not static monoliths". In other words, as people respond to changing social and environmental circumstances, certain cultural practices may change and re-emerge in new ways. While it may have been taboo for parents to talk to their children about issues of sexuality in the past, it is possible that new patterns of behaviour may have emerged, especially with unplanned pregnancy and HIV infection rates escalating amongst adolescents and young people. The extent to which these patterns of behaviour are similar or different for rural and urban parents is of interest in this study.

It can be expected that parents may be engaging in some level of communication with their adolescent children on sexuality in one way or another. This study aims to explore the nature of such communication, and to ascertain whether it is happening at all, what form it takes, and what triggers such communication where it occurs. However, this is done with an understanding that even though all participants for this study may be *Zulu*-speaking parents that reside within eThekweni Municipality in KwaZulu-Natal,

some level of diversity in their perceptions of parent-child communication on sexuality can be expected.

Bandura (2006) argues that the concept of territorial culturalism that categorises peoples in broad categories of nationalities and ethnic groupings is flawed as there is substantial diversity among societies that may be placed in one category. Therefore in this study it is acknowledged that while all the research participants may fall under the broad category of *isiZulu*-speaking parents in eThekweni Municipality, some diversity may be observed in terms of not only their perceptions of parent-child communication, but also in terms of how their structural and cultural contexts influence their agency to initiate and maintain effective parent-child communication on sexuality. This is why this study also investigates whether there are any cultural differences between younger and older parents, as well as between rural and urban parents.

Structure

Structure refers to “forms of social organising that provide or limit access to resources” (Basu & Dutta, 2009:89). In the Culture-Centred Approach, Dutta-Bergman (2005:108) argues that in addition to individual beliefs and perceptions, scholars and practitioners should also take cognisance of the “constraints that might operate in the individual’s environment, particularly in severely resource-deprived spaces such as third world nations”. Indeed Airhihenbuwa *et al*, (2000) argue that health communication efforts must take into consideration the social and physical environmental factors that impact on individual roles and expectations as these affect their health behaviour. They further point to five contextual domains that are an intrinsic part of the environment of a community, that is, socio-economic status, government and policy, culture, gender and spirituality (ibid).

According to the *Human Development Report 2014*, “when social and legal institutions, power structures, political spaces, or traditions and sociocultural norms do not serve members of society equally...they give rise to structural vulnerabilities”, which may create barriers for some groups of people to effectively engage in solving community health problems (Malik, 2014:70). In

addition to the exploration of cultural meanings ascribed by parents to the concept of parent-child communication on sexuality, this study then further explores the contextual environments of rural and urban spaces in order to glean insights on factors that could enable or hinder parent-child communication on sexuality. Beyond the physical environments of urban and rural spaces, the study further explores the macro environment of policy, availability of resources such as information on adolescent sexuality, including the language in which resources are available to analyse the extent to which these hinder or enable parent-child communication on sexuality.

Studies in other contexts have revealed that “socio-demographic factors such as sex, age, school attendance, parent level of education, religious affiliation and other household characteristics such as family size and marital status of parents play a role in determining the occurrence of parent-child communication on sexuality” (Bastien *et al*, 2011:13). In the same study, issues of lack of communication skills and information on sexuality were cited as barriers that prevented parents from communicating with their children on issues of sexuality (ibid:14).

According to Dutta (2011), marginalised communities have the capability to voice their opinions and ideas on health issues that affect them. The Culture-Centred Approach to health communication therefore provides an opportunity for the researcher to engage in a dialogic discourse with study participants to gain insight into structural factors that may impede or enable parent-child communication on sexuality within their rural or urban contexts.

Urban/ rural differences/settings and how they influence parent-child communication

It is widely acknowledged that “demographic and socio-economic factors, such as race, ethnicity, education, and income are strongly related to health and vary between rural and urban settings” (Eberhardt & Pamuk, 2004:1864). There is conclusive evidence that even with regards to health issues, particularly related to HIV prevention, there are noticeable urban/rural disparities in population-wide HIV infection rates, condom use amongst HIV

positive patients, and exposure to health promotion messages, with rural settings being more adversely affected than urban settings (Lurie *et al*, 2008). This implies that careful thought needs to be given to how health communication programmes can be tailored to respond to the specific structural impediments that each environment presents.

In this study, it cannot be assumed that the same parent-child communication programme on sexuality can suit both urban and rural contexts equally. This is due to the fact that many factors come into play, including access to information and other resources on sexuality education, as well as cultural beliefs and values that communities in either context may hold.

Agency

Agency refers to “the capacity of human beings to engage with structures that encompass their lives, to make meanings through this engagement, and at the same time, creating discursive openings to transform these structures” (Dutta, 2011:13). The Culture-Centred Approach to health communication then advocates a process of tapping into the “ability of individuals and their communities to be active participants in determining health agendas and in formulating solutions to a variety of health problems, as these are perceived by the community” (Dutta, 2011:7). Similarly, this study engages with parents as active agents in the process of formulating what works and what doesn’t work for their contexts in terms of parent-child communication on sexuality.

Agency is said to be located at its interaction with culture and structure (Dutta, 2011). In this study, the aim is to engage parents as active agents of change in the process of formulating solutions to challenges faced in initiating and maintaining effective parent-child communication on sexuality. This shifts the emphasis to the parents themselves as an entry point for the articulation of knowledge, as they get engaged in a participatory process that allows health communication scholars the opportunity to engage with the agency of the cultural participants (Dutta, 2011). It is the aim of this research to further gain an understanding of the parents’ agency in initiating and/or maintaining parent-child communication on sexuality.

One of the earlier scholars to theorise about the concept of human agency is Albert Bandura (1989, 1998, 2001, 2002, 2006). Based on his Social Cognitive and Social Learning theories, Bandura's assertion is that "people are self-organising, proactive, self-regulating, and self-reflecting...they are not simply onlookers of their behavior", but they are "contributors to their life circumstances, not just products of them" (2006:164). Closely linked to the concept of human agency is self-efficacy, which is the belief that people have the power to effect changes by their actions (Bandura, 2006).

While Bandura has theorised on the concept of human agency in general terms of human development, other scholars have applied the concept of human agency to specific areas of study, ranging from education (Schunk, 1991), organisational science (Boudreau & Robey, 2005), and many others, including on parenting (Dumka, 1996; Kullis *et al*, 2015).

The basic argument advanced in the scholarship of human agency is that people have the capacity to intentionally influence their functioning and their life circumstances. Therefore, as the concept of parent-child communication on sexuality is being explored with parents, this is done so with an understanding that parents are pro-active agents, and not just onlookers who are devoid of any agency. People are self-reflective, meaning they can reflect on their thoughts and actions, as well as on their changing environment, and then intentionally make corrective adjustments that are based on a visualised future (Bandura, 2006).

The purpose of this study, therefore, is to explore the nature of parents' agency in the rural and urban contexts, meaning that strategies that parents are using currently to communicate with their adolescent children on issues of sexuality will be explored. The extent to which their agency to communicate with their adolescent children is influenced by culture and structure, will also be explored, since, as Dutta (2008) asserts, agency becomes meaningful in its relationship with the structures within which healthcare experiences are embedded. The question of what parents perceive to be enabling or

prohibitive factors to initiating and maintaining communication on sexuality with adolescents will further shed light on parents' own visualised strategies for increasing their agency to communicate with their adolescent children on issues of sexuality.

Agency and parenting practices within a cultural context

A study by Dumka (1996) set out to explore the relationship between parenting self-agency and improved parenting practices. In this study, parenting self-agency was defined as “parents’ overall confidence in their ability to act successfully in the parental role” (ibid:216). The study was a cross-cultural and cross-language study that was conducted with English-speaking, middle-income parents, and Spanish-speaking, low-income migrant parents in the United States. The findings of this study indicated that parenting self-agency differs based on the socioeconomic status and ethnicity of parents. Parents who were experiencing economic hardship were found to have diminished self-agency and less effective parenting practices. Similarly in this study, the urban/rural divide presents socio-economic differences between parents who are in rural areas and those in urban areas. It is the intention of the researcher to explore whether there are any differences or similarities in parental agency in these two contexts. Listening to the voices of parents in this study will further elucidate the factors that parents perceive as enabling or prohibitive for them to initiate, modify, or maintain parent-child communication on sexuality with their adolescent children.

In another study exploring cultural influences in parents’ agency to communicate with their children on issues of sexuality, Kullis *et al*, (2015) worked with two groups of American Indian parents, one rural and urban. Their study sought to determine whether a culturally-grounded parenting programme with American Indian parents in urban settings would improve parents’ agency and positive parenting practices. The results of this study indicated that culturally adapted parenting interventions with parents of 10-17 year-olds significantly improved parental agency and parenting practices, thereby providing evidence that culturally grounded parenting programmes

are needed as they increase the likelihood of positive outcomes in young peoples' sexual behaviour.

The engagement in dialogue with research participants in this study, is an important aspect that facilitates an understanding of how “agency is enacted in the lives of individuals and communities as they struggle with the structural constraints that they face” (Dutta, 2008:8).

Dialogue

At the heart of CCA is the contention that dialogue is key in creating spaces for social change (Dutta, 2011). The voices of the community members for whom health communication programmes are being developed are important to be listened to. In other words, if programmes on parent-child communication are to succeed, the voices of parents are key in understanding the cultural, structural and agentic factors that may promote or hinder parent-child communication on sexuality.

In his critique of the dominant discourse largely perpetuated by the West, Dutta (2008) advances the argument that health communication programmes are predominantly characterised by a top-down approach where programmes are conceptualised and planned at the ‘centre’, and then delivered to target audiences with the intention to modify their behaviour in one way or another. He argues that this ‘centre-periphery’ phenomenon is largely defined by unequal power relationships where those with access to power conceive and implement messages towards the target audiences that are perceived to be passive and without any agency.

The CCA to health promotion seeks to disrupt this approach by engaging in dialogic processes with participants where their experiences and voices are amplified, and then used to inform programmes that are implemented on their behalf. It is such an engagement that introduces “the voice of local communities into the ways in which issues of health are understood, interpreted and communicated” (Dutta, 2008:60). Similarly in this study,

engaging in dialogue with parents of adolescents is key to understanding their perceptions of parent-child communication on sexuality within their particular structural and cultural context. It is the voices of the parents themselves that are amplified and given space to inform programming that may seek to address the issue of parent-child communication on sexuality.

The CCA to dialogue maintains that dialogue affects and is, in turn, affected by social structures, culture and the agency of community members (Dutta, 2011). Engaging study participants in dialogue, therefore, allows for the exploration of the agency of communities to engage with the cultural and structural constraints that they face in communicating to their children about issues of sexuality.

Dialogue and anti-dialogue

On one hand, dialogue has been framed as a horizontal relationship between two persons (A and B), where there is genuine two-way communication, involving empathy and mutual recognition (Freire, 1970). Anti-dialogue, on the other hand, involves a vertical relationship of person A over person B, and involves person A sending out communication to person B without empathy or recognition (Hook, Franks & Bauer, 2011).

Many health communication campaigns have used this monologic type of communication where messages are sent out to communities to persuade them either to change what may be perceived as unhealthy behaviours, or to adopt new behaviours. In most cases, these campaigns are conceptualised from a Western or Eurocentric knowledge base, and then enforced onto marginalised communities in the form of persuasive messages in health promotion campaigns.

Anti-dialogical approaches to health communication have historically placed 'health professionals' in the position of 'expert' who possesses the most accurate knowledge about health, while at the same time placing the 'uneducated' public at the opposite end of the education spectrum (Hook,

Franks & Bauer, 2011). This study seeks to employ authentic dialogue with study participants, the parents, and engage them to discover what their perceptions are about parent-child communication. Such a dialogue will further shed light on factors that may promote or hinder parent-child communication on sexuality, especially with regards to cultural and structural factors that inform their context.

The need for authentic dialogue with target audiences in health communication has also been re-iterated by Petraglia (2009:181) where he calls for the use of dialogue as a communicative ideal, and “not merely the means that allow for the exchange of information but a self-actualizing process that creates conditions for happiness, dignity and justice”. It is this type of authentic dialogue which, he says lies at the heart of health communication.

In this process of amplifying the voices of marginalised communities, Dutta (2011) cautions against the researcher assuming the position of representing or being the spokesperson for the research participants. Instead, he advocates an understanding where the researcher engages in this dialogical relationship with the intention to gain a sense of understanding, as opposed to attempting to find solutions on behalf of marginalised communities. Similarly, in this study, the intention is to gain an increased understanding of parents’ perceptions of parent-child communication on sexuality, and to gain further insight on whether differences exist between rural and urban parents, and younger and older parents.

The application of the CCA to parent-child communication on sexuality

The Culture-Centred Approach to health communication is built upon three constructs, namely; culture, structure, and agency (Dutta, 2008, 2011). Being founded on the idea that traditional health communication theories and applications have contributed to an erasure of cultural members’ voices in constructions of health, the Culture-Centred Approach to health

communication “primarily focuses on understanding health meanings and experiences in marginalized settings” (Dutta, 2008:4).

This study seeks to explore rural and urban, and older and younger parents’ perceptions of parent-child communication on sexuality. This is done by engaging in dialogue with parents in these different contexts with the aim of understanding the kind of communication parents are currently having with their children on sexuality, the factors parents perceive as inhibitive or enabling for them to be able to initiate and maintain parent-child communication on sexuality, as well as exploring what parents need in order for them to be able to initiate and maintain parent-child communication on sexuality.

The concept of agency allows the researcher to explore parents’ agency in initiating communication on sexuality issues. The cultural and structural concepts, as proposed by Dutta (2008), help to promote an understanding of how parents’ abilities to communicate with their adolescent children on sexuality are influenced by their cultural and structural contexts. The researcher is conscious of the fact that these three constructs of the Culture-Centred Approach to health communication cannot be treated singularly, and in isolation from one another.

The three concepts of culture, structure and agency are intertwined (Dutta, 2008). Parents’ interactions with social structures are influenced by culture, and culture also influences the agency of parents in initiating and maintaining parent-child communication on sexuality. It is the intention of this study to explore the extent to which this interplay of culture, structure and agency influences parents’ perceptions of parent-child communication on sexuality.

Limitations of the Culture-Centred Approach

The Culture-Centred Approach to health communication provides a unique opportunity for community voices that have previously been absent from the dominant discourse on health communication, to be heard with regards to

their own solutions for health challenges that they face. In contrast to the cultural sensitivity approach, which proposes health communication solutions that are sensitive to the characteristics of the culture, the Culture-Centred Approach to health communication proposes the identification of health problems and their solutions from within the culture, and advocates for cultural members to be active participants in solving their own health problems.

However, caution must be taken in how the concept of culture is used and understood. Bandura (2002) maintains that cultures are socially diverse and dynamic, and further argues that there can be significant heterogeneity amongst individual members of one perceived cultural entity. The way in which culture is conceptualised in the Culture-Centred Approach to health communication does not explore this complexity, and this may lead to generalised conclusions about a certain cultural group that are not necessarily true for all members of that group.

Furthermore, the proliferation of information technologies and the information highway through the worldwide web has given rise to virtual communities that come together based on specific cultural traits such as sporting interests, political convictions, ethnic and religious groupings, and many others. The Culture-Centred Approach to health communication theorises cultural confines based largely on spatial geographic dimensions only, and does not explore this phenomenon adequately.

Further to this, domination in the Culture-Centred Approach to health communication is seen as always being exerted from the outside, for example, the coloniser to the colonised, when in fact, members of the same cultural group can exercise domination within cultural groupings. The Culture-Centred Approach to health communication also seeks to foreground community voices in health communication discourse, but does not provide specific guidelines for how researchers and programme implementers can practically undertake this exercise.

A final, but equally important, limitation of the Culture-Centred Approach to health communication is the romanticisation of cultural members as being uniformly able and willing to effect changes to their environments. In reality we know that this romanticised notion of cultural members does not always hold true as members within a particular culture may hold dissenting views about their own development, and may not necessarily be of one mind in terms of proposed solutions to community health problems.

This chapter has set out to outline the theoretical and conceptual underpinnings of this study. The SEMCHB has been outlined as the conceptual framework within which this study is located. The SEMCHB provides the basis for our understanding of the location of parent-child communication on sexuality within a broader, multi-level approach to health communication aimed at improving sexual and reproductive health outcomes for adolescents.

The Culture-Centred Approach to health communication, in turn, foregrounds the theoretical constructs of culture, structure and agency in exploring the concept of parent-child communication, and provides a theoretical framework within which to forge a better understanding of parents' perceptions of parent-child communication on sexuality.

In the next chapter, the research methodology used in this study will be explained.

CHAPTER FOUR - RESEARCH METHODOLOGY

The research philosophy you adopt contains important assumptions about the way in which you view the world. These assumptions will underpin your research strategy and the methods you choose as part of that strategy (Saunders, Lewis and Thornhill, 2009:108).

Introduction

This section outlines the research methodology that was adopted for this study. However, as Saunders *et al*, (2009) state, the research strategy and methods that are chosen by any researcher inherently reflect the research philosophy of the researcher, and this must be outlined and clearly explained for the reader. As such, this section outlines the research paradigm that informs the researcher's mode of enquiry, the researcher's ontological and epistemological position, the research design, research method, sampling strategy, method of data analysis as well as ethical considerations. Matters of rigour such as trustworthiness are also described in this chapter.

The research paradigm

According to Guba and Lincoln (1994:107), "a paradigm may be viewed as a set of basic beliefs...that deals with ultimates or first principles...and which represents a worldview that defines, for its holder, the nature of the world, the individual's place in it, and the range of possible explanations to that world and its parts". The above authors further point out that any paradigm that a researcher purports to base their study on, is further constrained by that researcher's answers to three fundamental questions, namely;

- a) *Ontology* – what is the form and nature of reality?
- b) *Epistemology* – what is the relationship between the knower and the would-be knower?
- c) *Methodology* – how can the researcher go about finding out whatever she or he believes can be known?

Therefore, this section provides the research paradigm adopted in this study, and an outline of the three fundamental questions, which undergird the beliefs assumed by the researcher.

In this study of rural and urban parents' perceptions of parent-child communication on sexuality, the researcher is interested in participants' own constructions of the concept of parent-child communication from their multiple realities that are informed by their particular location (rural and urban) and age (younger and older) cohorts. Meaning is said to be *constructed* and not discovered, which implies that people construct their own meaning in different ways, even in relation to the same phenomenon (Gray, 2013). In this study, the concept of parent-child communication on sexuality is understood as being subject to different meanings, perceptions and interpretations by the different groups of parents involved. As such, this research is located within a constructivism paradigm of inquiry, which "assumes multiple, apprehendable, and sometimes conflicting social realities that are the products of human intellects..." (Guba & Lincoln, 1994:111).

Constructivism is closely related to interpretivism and interpretive approaches concentrate on meanings people mobilise to make sense of their world (Deacon, Pickering, Golding & Murdock, 1999). In addition, an interpretive philosophical stance is based on the belief that all knowledge is co-produced out of the multiple encounters, conversations and arguments (researchers) have with the people they are studying (ibid).

In contrast to the positivist philosophical stance which asserts that there is an objective reality 'out there', this research is informed by an ontological view that acknowledges reality as being socially constructed, subjective, liable to change and that there exists not only one objective account of the world, but multiple, contradictory but equally valid accounts of the world (Gray, 2013).

While Guba and Lincoln (1994) maintain that constructivism and critical theory are different paradigms of inquiry, Dutta (2008) acknowledges that while the Culture-Centred Approach to health communication draws much of its

impetus from critical theory, it is also influenced by cultural studies scholarship which emphasises social constructions of discourse and health narratives that are situated within a cultural framework of understanding. The researcher therefore, acknowledges the blended nature of this inquiry, where the aim is to understand the perceptions of parents on parent-child communication on sexuality for deeper insight across various cultural contexts, as well as facilitating a critical appraisal of the phenomenon from a cultural perspective, that may lead to transformation and emancipation.

The aim of this inquiry, therefore, is to explore the ways in which parents in the study settings selected for the current study, make meanings of the concept of parent-child communication on sexuality, and how culture, structure and agency interact to inform their perceptions of the phenomenon.

The epistemological stance of the researcher is that social phenomena have subjective meanings and therefore it is important to focus on the reality behind the details and to uncover these subjective meanings and motivating actions (Saunders, Lewis & Thornhill, 2009). This means that my task as the researcher is to engage research participants in a dialectical and dialogic process with the aim of uncovering their perceptions of the phenomenon under investigation, that is, parent-child communication on sexuality.

Health as conceptualised in the dominant approach is typically removed from the context that surrounds it and health communication in the dominant paradigm is characterised by an emphasis on rational actions by individuals (Dutta, 2008). In advancing the case for a Culture-Centred Approach (CCA) in health communication, Dutta (2008) advocates instead for scholarly inquiry that interrogates contextual factors in order to uncover the hidden meanings in people's lived experiences by opening up spaces for peoples' voices to be heard through an authentic dialogical engagement with them. The method of inquiry in this study is informed by the above epistemological standpoint hence, the research participants are given the space to voice their own interpretations, perceptions, and opinions on parent-child communication on sexuality.

It is envisaged that this dialogic process will yield deeper insights into the phenomenon of parent-child communication on sexuality in the context of KwaZulu-Natal, while in turn, providing the research participants with a communicative space where their voices can be heard.

Methodological map	
Research Paradigm	Interpretivism/Constructivism
Research design	Qualitative research
Sampling technique	Purposive sampling
Data collection method	Focus group discussions
Data analysis package	Thematic analysis

Table 4.1 – Methodological Map of the study.

Research design

The current study is a qualitative research study, and the interest of the researcher is on understanding the issues being researched from the perspective of the research participants; hence the researcher is interested in listening to the voices of the parents in terms of what their perceptions are regarding parent-child communication on sexuality (Struwig & Stead, 2013). As Struwig and Stead (ibid) further point out, people's behaviour is inextricably linked to their contextual environment, and so this study also explores research participants' perceptions from their group contexts, hence the focus on culture and structure.

Qualitative research involves the study of things in their natural settings, with attempts to interpret phenomena in terms of the meanings that people bring to them, and using a variety of materials to collect empirical evidence, such as case studies, interviews, cultural and visual texts and people's personal experiences, amongst others (Denzin & Lincoln, 2008). Qualitative research is often contrasted with quantitative research, which emphasises the measurement and analysis of causal relationships between variables (Guba & Lincoln, 1994). Whereas qualitative research explores the socially constructed

nature of reality, including how social experience is created and given meaning, quantitative research is more concerned with quantities, amounts, and frequencies of entities under investigation (Denzin & Lincoln, 2008).

A qualitative research design has been adopted in this study, as the interest of the researcher is to explore the meanings that parents ascribe to the concept of parent-child communication on sexuality, from their cultural perspectives. This qualitative research design is informed by the principles of ethnography, whose primary purpose is to describe and explain the world of the research participants in the way that they would describe it (Saunders *et al*, 2009). Ethnographic research places a focus on culture (Gray, 2013), and is therefore well-suited to this study which is framed within a Culture-Centred Approach to communication.

Study site

This study is set in two locations, one rural and one urban in the eThekweni Municipality in KwaZulu-Natal province, South Africa. The first site is the rural area of Umnini, which is characterised by inadequate road infrastructure, health facilities that are few and far in-between, low literacy levels especially amongst the older population, low education levels with only 4,9% of the population aged 20 years and above having a higher education qualification, and 28,8% having a matriculation qualification (Statistics SA, 2011). The Black African, Zulu-speaking population makes up most of the area at 99,4%. There is evidence of high pregnancy rates amongst adolescents attending schools that fall within the category of 'most deprived' and lowest quintile category at Umnini (Milford, Beksinska, Kubeka & Smit, 2004).

The second site is Queensburgh, which is an urban setting. Queensburgh has education levels that are slightly higher with 21,3% of the population aged 20 years and above having a higher education and 40,8% of the population having a matriculation qualification. The Black African, Zulu-speaking population makes up 23,8% of the total population of Queensburgh, with the majority being English-speaking (Statistics SA, 2011). Queensburgh is situated in the Pinetown District and is reported to have high adolescent

pregnancy rates, making it eThekweni Municipality's target area for actions to reduce adolescent pregnancy (eThekweni Municipality, 2015).

The current study compares the perceptions of parents from these two areas in order to discover similarities and/or differences that may exist in their perceptions of parent-child communication on sexuality. The researcher is interested in exploring how parents make meaning of the concept of parent-child communication on sexuality from their different contextual perspectives, in order to facilitate a deeper understanding of cultural and structural factors that may promote or hinder parent-child communication on sexuality.

Listening to parents' voices from these two different structural contexts may reveal critical insights that may serve to inform future directions in the planning and implementation of health communication programmes targeting parents on issues of adolescents' sexuality.

Population

Parents that are currently raising a male or female adolescent between the ages of 10 and 19 years were selected to participate in the four focus groups conducted for the study.

According to the WHO, parents are defined as "all those who provide significant and/or primary care for adolescents, over a significant period of the adolescents' life, without being paid as an employee, including biological parents, foster parents, adoptive parents, grandparents, other relatives and fictive kin such as godparents" (WHO, 2007:7). As such, parents that were eligible to participate in this study could be married, unmarried, single, biological or non-biological parents or caregivers of adolescents. The varied categorisations of parents mentioned above were not the primary interest of this study. Rather, the researcher was interested in listening to the voices of all types of parents that fit the criteria mentioned above. While it is understood that some children take on the role of parents in child-headed households, such children were not recruited for this study.

Target Population

Further criteria that were used to select the groups of parents for the study were the following:

- a) Rural parents under the age of 45 years;
- b) Rural parents above the age of 45 years;
- c) Urban parents under the age of 45 years;
- d) Urban parents above the age of 45 years.

Both male and female parents were recruited for each focus group. The term 'parents' was loosely defined and referred to any adult that was currently raising an adolescent child between the ages of 10 and 19 years. The researcher was interested in listening to the voices of rural and urban isiZulu-speaking parents of adolescents. As such, it was only parents that speak isiZulu as their home language that were selected to participate in the study.

Sampling method

The current study set out to explore parents' perceptions of parent-child communication on sexuality in rural and urban settings. It follows logically then that the people who are best positioned to provide insight into this phenomenon would be the parents of adolescents themselves, located in rural and urban parts of eThekweni Municipality. As a result, the sample of parents that was included in the study was selected using non-random or non-probability sampling, meaning that they were "purposely selected" (Deacon *et al*, 1999:44).

While Kitzinger (1995) advocates for randomisation in the selection of participants for focus group discussions, Krueger and Casey (2015) caution against this strategy, their argument being that the aim in qualitative research is not to infer results to a larger population (which is usually the aim with random selection), but rather to facilitate an understanding of an issue or situation being studied. As such, purposive sampling in this study was used

not necessarily to make generalised statements about parents in rural and urban areas, but rather to gain deeper insights into how the different categories of parents (younger rural, older rural, younger urban, and older urban) perceive parent-child communication on sexuality.

The researcher was particularly interested in using purposive sampling because it would ensure that participants who have proximity to the issue under investigation, namely parent-child communication on sexuality, were selected.

Recruitment strategy

Parents from rural Umnini were recruited with the help of a community-based organisation operating in that area, *Umgogodla Community Organisation*. A recruitment screener that contained criteria for the selection of research participants was developed (see Appendix 1). The recruitment screener is a document that provides details of the categories that must be fulfilled for parents to qualify for participation in the study. The recruitment screeners for the two groups of parents were given to the organisation and one staff member in the organisation then recruited parents telephonically and in person, using the recruitment screener. Both the focus group discussions with rural parents were conducted in the facilities of *Umgogodla Community Organisation*, in a room large enough to accommodate twenty people. The venue was easy and convenient for all participants to access due to its proximity to the participants' homes.

Urban parents from Queensburgh were recruited through a community church, the *Congregational Church of Queensburgh (CCQ)*. The church was selected for convenience and ease of recruiting parents that would fit the criteria for participation in the study. Recruitment criteria were provided to the church and the church secretary then recruited parents accordingly. While recruitment was done through the church, parents that participated in the study did not necessarily have to be members of the church, and so the focus group discussions (FGDs) in this location consisted of a mix of parents from

the church, and those not from the church. This was to mitigate against religious bias that might have threatened the credibility of the findings from this location. Both focus groups for urban parents were conducted in the church hall, a venue that was big enough and familiar to all participants. The venue was accessible to all parents as it was close to their homes.

Data collection

This sub-section will include details of the data collection methods used (focus group discussions), the rationale for using focus group discussions, group selection, group size, standardisation and the number of groups.

Defining focus group discussions

Different scholars in the social sciences have defined focus group discussions (FGDs) in various ways. Focus group discussions are defined as a “research technique that collects data through group interaction on a topic determined by the researcher” (Morgan, 1996:130). Key to the above definition are the three constructs of focus group discussions as a data collection method, the primacy of interaction amongst group members, and the active role of the researcher in moderating the discussion.

An additional dimension to focus group discussions is their ability to explore a specific set of questions around a particular issue, therefore being “ideal for exploring people’s experiences, wishes, opinions and concerns” (Kitzinger & Barbour, 1999:5). As such, focus group discussions were the ideal method for this study as the researcher was interested in listening to parents’ experiences, wishes, opinions and concerns regarding the issue of parent-child communication on sexuality.

The focus group discussion methodology is not only about getting a group of people to talk, but is a carefully constituted group with a specific purpose of gathering opinions that help the researcher to better understand how people feel and think about an issue, idea, product or service (Kreuger & Casey, 2015). Additionally, focus group discussions “can help people to explore and clarify their views in ways that would be less easily accessible in a one to one

interview”, especially when the interviewer wishes to ask open-ended questions and encourage the exploration of issues that are important to the research participants, in their own vocabulary (Kitzinger & Barbour, 1995:299).

Focus group discussions embrace the concept of the researcher working together with the research participants to uncover new meanings. In keeping with the CCA to health communication, focus group discussions allow the researcher to gain a sense of understanding of participants’ perspectives through authentic dialogue (Dutta, 2008).

Similarly in this study, focus group discussions as a methodology have been selected for their ability to foreground the voices of *isiZulu*-speaking rural and urban parents of eThekweni Municipality, that have previously been absent from the dominant discourses on parent-child communication on sexuality.

Rationale for using focus group discussions

The focus group discussion method was selected for its usefulness in providing a platform for participants to interact with one another as it provides an opportunity for the exchanging of anecdotes, and for participants to comment on each other’s experiences and points of view (Kitzinger & Barbour, 1999). This aspect of interpersonal interaction amongst participants was a particularly important consideration in this study as it has the advantage of highlighting (sub) cultural or group norms, and allows the researcher to identify shared and common knowledge by study participants and to observe dominant cultural values (Kitzinger, 1995).

In the Culture-Centred Approach, it is crucial for the researcher to build this discursive space by allowing for the sharing of stories between the researcher and the study participants, hence the selection of focus group discussions as a method of inquiry for this study (Dutta, 2008).

Group selection

Due to the framing of the study within a Culture-Centred Approach to health

communication, it was important to ensure a level of homogeneity in each group as the researcher was interested in listening to shared narratives and perceptions within each group. A report on adolescent pregnancy notes disparities between rural and urban adolescents, with an overall adolescent birth rate in rural settings reported to be 2.8 times higher than that in urban areas (UNFPA, 2013). In addition, Eberhardt & Pamuk (2004) maintain that much research on health issues has focused on urban areas, and they make recommendations for rural health research to be equally documented in order to address the health disadvantage of rural areas and to guide more efficient policy-making decisions, given the limited resources in various contexts.

In South Africa, Peltzer (2006) compared sexuality and sexual behaviour among 16 to 17 year-olds and found significant differences between rural and urban adolescents, and further recommended that these differences need to be considered in designing sexuality education programmes for South African adolescents. This rural/urban disparity was therefore important to consider and the comparison between rural and urban parents is in light of this consideration. From a culture-centred perspective, it was important to provide space for the foregrounding of the voices of cultural participants in a way that reveals the distinct structural, cultural and agentic enablers/inhibitors of parent-child communication on sexuality, from a rural as well as an urban perspective.

Other studies have found differences in parents' perceptions between older and younger parents, with younger parents being found to be more receptive of the concept of parent-child sexuality communication than their older counterparts (Akinwale *et al*, 2009). This may be linked to the assertion by Meggiolaro and Ongaro (2013) that older mothers are more likely to conform to traditional stereotypical beliefs in their child-rearing practices.

Research shows that the median age at first birth is 21 years for all age cohorts in South Africa (StatsSA, 2011). This means that the majority of South African women have their first birth between the ages of 20 and 24 years, placing the majority of parents of adolescents at the ages of between 35 and

45 years when their children reach the stage of adolescence (10-19 years). Due to the fact that a significant number of parents will have subsequent births after the first birth, some parents may still be parenting adolescents by the time they are above the age of 45 years. The typical age for parents of early adolescents has been stated to be between 30 and 45 years (Kulis, Ayers & Baker, 2015). This study uses the cut-off line between younger and older parents of 45 years of age, therefore, due to the above explanation.

This age dimension was also important to investigate in this study; hence the selection of younger and older parents for separate focus group discussions. The comparison between younger and older parents in both sites was aimed at providing insight on cultural and agentic factors that can enable or inhibit parent-child communication on sexuality.

Group size

Each group consisted of both men and women and each focus group discussion was made up of between seven and ten participants. A total of 33 parents participated in the four FGDs that were conducted for this study. The younger rural group comprised of nine parents who were all female. The older rural FGD had a total of eleven parents, with three males and eight females. The younger and older urban FGDs both had a total of 7 parents each, with 2 parents being males, and five being females in both groups. Group size and composition is further illustrated in Table 4.1 below.

FGD participants	Rural younger	Rural older	Urban younger	Urban older	TOTAL
Male	0	3	2	2	7
Female	9	8	5	5	27
TOTAL	9	11	7	7	34

Table 4.2 – FGD participants for the study

According to Kreuger and Casey (2015), determination of the size of the group should be informed by the purpose of the study and participant

characteristics. These authors argue that in order to gain an understanding of people's experiences and opinions, more in-depth insights will be gained from smaller focus groups (ibid). Smaller groups also provide the participants with the opportunity to share experiences and interact with each other more than what is the case with bigger groups.

In keeping with the Culture-Centred Approach's philosophy of amplifying participants' voices by providing dialogic spaces for their voices to be heard, group size was an important consideration that would ensure that all participants in the group were able to express themselves, thereby amplifying their voices concerning the issue under investigation.

Standardisation

Standardisation addresses the extent to which the identical questions and procedures are used in every group (Morgan, 2015). As this study explores the perceptions of parents across four different groups it was important for the researcher to standardise the questions and procedures across the different groups selected for the study. The advantage in this exercise was that analysis of focus groups would allow for direct comparisons of the discussions between groups (Morgan, 1998).

Since standardisation has the disadvantage of rigidity in application, the researcher worked with a fellow PhD student (who is also a parent to two adolescent boys) to formulate the research questions as well as to pilot test the question guide before it was applied in the actual focus group discussions. Minor adjustments were made to the question guide, mainly involving the sequencing of questions, after feedback was provided.

Number of groups

The number of FGDs that is chosen for any study is dependent upon the aims of the project and the resources available to the researcher (Kitzinger, 1995). The rule of thumb regarding the number of groups is four to six focus groups (Morgan, 1998). As a result, four groups were identified for the study, namely; (a) younger rural, (b) older rural, (c) younger urban and (d) older urban parents.

Data analysis

In keeping with the qualitative research design of this study, data analysis was conducted using Thematic Analysis which is “a method for identifying, analysing, and reporting patterns (themes) within data and minimally organises and describes data set in (rich) detail” (Braun & Clarke, 2006:6). The data that was generated from the focus group discussions was analysed using manual Thematic Analysis, meaning that no computer software was used to analyse the data. The data were coded inductively; there was no attempt to fit them into any pre-determined coding frames (Braun & Clarke, 2006).

Since the focus group discussions were conducted in the *isiZulu* language, they were first translated into English and then transcribed. Once the audio was transcribed, the transcripts were read through, with the aim of identifying initial codes from the data that identify a feature of the data that appeared interesting to the analyst (Braun & Clarke, 2006). The aim, however, was to use these initial descriptive, thematic and analytic codes to generate recurring themes and sub-themes that could form the basis of data analysis. Major themes and sub-themes emerging from the data were refined, and consequently formed the basis for the analysis that made the argument in relation to the research questions, and the theoretical underpinnings of this study.

Thematic Analysis was conducted at a latent level, which means that the researcher was interested in exploring “underlying ideas, assumptions and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data” (ibid:84). In this way, the researcher would be able to explore the socio-cultural context of the research participants, as well as the structural factors that influence the practice of parent-child communication on sexuality.

To ensure rigour in the analysis process, Braun and Clarke’s (2006) six-step process for thematic analysis was employed. Firstly, all the FGDs that were

undertaken for this study were recorded, and the recordings were translated into English and transcribed, as the FGDs were conducted in isiZulu. The transcripts were then printed out and read repeatedly to establish patterns and meanings that may arise, and initial ideas were noted down in writing.

The second phase involved the production of codes that identify some specific features of the data. Since the analysis was theory-driven, codes were in relation to the key constructs of the theoretical framework used. The researcher was interested in first identifying codes that were related to culture, structure and agency, the key constructs of the CCA. However, the researcher left space for some codes that might add deeper insight into the analysis to emerge from the data. All emerging codes were added to theory-related codes.

The third phase involved sorting the codes into potential themes. A mind-map was used to make a visual representation of the themes that emerged. However, at this stage, the themes needed further refining, and so step four in the analysis was embarked upon. In phase four, themes were reviewed and further narrowed down and/or re-organised to create new themes, where necessary. There were eight themes that had emerged, and which were reviewed at this stage, to further ensure that they can be organised into sections that relate to the theory, as well as to the literature that had informed the study. Phase five involved the development of refined themes that would form the basis for the analysis report. Where necessary, sub-themes were created for each major theme to ensure that all relevant aspects of the data were captured, and to make it easy for the reader to capture the salient themes and sub-themes.

The themes and sub-themes that emerged during this process are outlined in the *Analysis of Findings* chapter, which follows after this chapter.

The final and sixth step in the analysis process was the writing up of the analysis report, in a way that relates findings to the research questions, as

well as the main constructs of the theoretical framework adopted for this study. The write up of the analysis is presented in the next chapter.

Table 4.3 below presents a diagrammatic representation of the thematic analysis process that was followed.

Phase	Description of the process
1. Familiarising yourself with the data	Data was transcribed, then read and re-read, noting down initial ideas.
2. Generation of initial codes	Interesting features of the data were coded in a systematic fashion across the entire data set, collating relevant data to each code.
3. Searching for themes	Codes generated in Step 2 were collated into potential themes
4. Reviewing the themes	Themes were checked if they work in relation to the coded extracts and the entire data set, and a thematic 'map' of the analysis then emerged.
5. Defining and naming themes	There was an on-going analysis to refine the specifics of each theme, and the overall story the analysis tells, and clear definitions and names for each theme and its sub-themes were generated.
6. Producing the report	Vivid and compelling extracts from the transcripts were selected and analysed, with a focus on the research questions for the study, and in light of the theoretical framework for the study.

Table 4.3 – Thematic Analysis steps followed (Adapted from *Braun and Clarke, 2006:87*)

Ethical considerations

Ethical aspects that were considered for this study were language, gatekeeper access, participant consent, recording, and accessibility of the

venues that were used for the FGDs. This was done to ensure that the study was conducted in an ethical manner, and as prescribed by the University of KwaZulu-Natal's (UKZN) Humanities and Social Sciences Research Ethics Committee (HSSREC).

Language

In order to facilitate for authenticity in participants' responses to questions, the FGDs were conducted in the mother tongue of the participants, *isiZulu*, and were later translated into English and then transcribed. This was to ensure richness in the data collected.

Gatekeeper access

A letter giving permission for the focus groups discussions to take place at the Queensburgh church was sought and granted prior to the recruitment of participants for the study. It is attached as Appendix 2.

A letter seeking permission to gain access into Umnini group of parents was sought and granted by a non-governmental-organisation (NGO) that works in the community, DramAidE. This was also done prior to the recruitment and conducting of the focus group discussions, and is attached as Appendix 3.

Participant consent

The purpose of the study was explained to the participants beforehand, and all participants were informed of their right to withdraw from participating in the focus group discussion, and that this would have no negative effects on them. All participants signed consent forms to agree to participate in the study voluntarily and without coercion. Consent forms were written down and a copy was handed to each participant before the start of each focus group discussion. The consent forms were printed on both sides, with one side being in *isiZulu*, and the other side being in English. The consent forms are attached as Appendix 4 (English) and Appendix 5 (IsiZulu).

The researcher explained the purpose of the study, and read through the consent form aloud, making sure that participants understood each section of the form. Participants were free to read either section, whether *isiZulu* or

English. Once the researcher had read through and explained all the contents of the consent form, participants were asked to sign the consent form to indicate that the form had been explained to them and that they understood all its contents. Participants were also informed that no financial compensation would be provided; there was no need for transport re-imbursement as all participants came from homes that are a walking distance to the venues.

The need to maintain confidentiality of discussions was explained as each participant's responsibility prior to the commencement of the focus group discussions. Participants were given the opportunity to ask any questions before the focus group discussion started, and were further referred to the University of KwaZulu-Natal's (UKZN) Humanities and Social Sciences Research Ethics Committee (HSSREC) should they have additional questions after the focus group discussions were completed.

Recording

Permission was sought from participants for the focus group discussions to be audio recorded. All participants signed for permission to record proceedings on a section of the consent form provided to them.

Accessibility of the venue

In both sites, emphasis was placed on recruiting parents that live close to the focus group discussion venue, to ensure that no participants incurred transport costs for coming to the venue. The venues were decent and well ventilated.

Validity, reliability and trustworthiness of the research

It has been stated that rigour is important in the research process, and that increasing rigour helps the researcher to address issues of validity and reliability (Struwig & Stead, 2013). However, the concepts of validity and reliability in qualitative research are contested as they have been more closely linked to quantitative research studies (Struwig & Stead, 2013). It has been recommended that qualitative researchers should instead ensure trustworthiness of the research, meaning that evidence must be shown that the research is to be trusted and believed (Shenton, 2004).

The following measures were put in place in this study to ensure the trustworthiness of the research:

- a) The focus group question guide was developed and used consistently amongst all four groups, ensuring that measures used would yield similar results if applied on other occasions.
- b) Transcriptions were made of all four FGD recordings, and other researchers would reach similar observations from a reading of the transcriptions.
- c) An 'audit trail' of all research tools used was kept and is available to provide transparency to the research and to verify all the steps that were taken in this research.
- d) The researcher worked with a fellow student (Doctor of Philosophy - PhD) who performed the function of a peer debriefer in the development of recruitment tools for the study, in conducting the FGDs, as well as in debriefing sessions after each FGD in order to ensure that initial thoughts and ideas from the participants' inputs are verified and noted down.
- e) The research methods used are well-established methods in qualitative research.
- f) The design and implementation of the research was described in detail.
- g) Recordings were transcribed in such a way as to capture the small nuances of silences, laughter and other gestures that participants made when discussing in the FGDs.
- h) The analysis report was written in detailed and thick descriptions that provide a clear picture of what was discussed in the FGDs.

Limitations to the study

There were a total of four FGDs conducted for this study. While the aim was to have equal representation of male and female parents in each group, this was not achieved due to lack of positive responses from males that were recruited for this study. Out of the 34 participants recruited for this study, only seven were male participants. However, the male participants in all FGDs participated actively and engaged fully in all discussions, and helped to

provide the male perspective on all questions asked. The data from this study will be presented and analysed in the next chapter.

CHAPTER FIVE - DATA PRESENTATION AND ANALYSIS

Introduction

This section will present, as well as provide a detailed analysis of the data that was gathered in the four focus group discussions that were conducted for this study. Two focus group discussions were conducted with rural parents; one with parents younger than 45 years of age (*identified as **younger rural***), and one with parents older than 45 years of age (*identified as **older rural***). Two focus group discussions were conducted with urban parents; one with parents younger than 45 years of age (*identified as **younger urban***), and one with parents older than 45 years of age (*identified as **older urban***). Rural parents were from Umnini, which is a rural area situated about 40 kilometres south of Durban. Urban parents were from Queensburgh, which is an urban area situated on the West of Durban.

The categorisation of the groups was to enable the researcher to investigate whether there were any differences in parents' perceptions according to their age and geospatial locations with urban-rural contrasts. Previous research (Akinwale *et al*, 2009; Vilanculos & Nduna, 2017) conducted in other parts of Sub-Saharan Africa suggests that there may be differences in perceptions between younger and older parents. Statistics South Africa (2011) figures reveal that the majority of parents of adolescents in South Africa are between the ages of 35 and 45 years. However, many parents continue childbearing after the first child, which results in a significant number of parents to continue parenting adolescents even after they have turned 45 years of age. In addition, a significant number of adolescents are being raised by their grandparents due to either death of biological parents, or parents being away from home for other reasons. Based on previous research and the socio-cultural context of parenting, younger parents for the purpose of this study are adults below the age of 45 years, while older parents are those older than 45 years of age. There is literature that points to differences between rural and urban areas in terms of adolescent pregnancy rates and other health factors (Eberhardt & Pamuk, 2004; Peltzer, 2006; Loaiza & Liang, 2013). This

necessitated an investigation into urban and rural differences in perceptions of parents on parent-child communication on sexuality.

Thematic analysis was systematically used to identify and analyse themes that were embedded within the data, with the aim of providing a rich interpretation of the meanings contained in the data that was collected. Thematic analysis “can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on, are the effects of a range of discourses operating within society” (Braun & Clarke, 2006:81). Accordingly, parents’ accounts of their experiences in communicating with their children on issues of sexuality were examined to explore underlying ideas, assumptions and conceptualisations, and this led to the uncovering of meanings that emanate from a range of discourses in both urban and rural areas that are the focus of this study.

In keeping with the Culture-Centred Approach to health communication (Dutta, 2008), which underscores the importance of the voices of marginalised communities being amplified through a dialogical engagement with that community, this section presents and comprehensively explains how parents perceive parent-child communication on sexuality from their own cultural perspectives. While maintaining focus on the theoretical underpinnings of this study, an inductive approach was utilised to generate the following latent themes:

- 1) Parents’ current approaches to parent-child communication on sexuality.
- 2) Factors that influence parent-child communication on sexuality.
- 3) Parents’ perceptions of parent-child communication on sexuality.
- 4) Parents’ strategies for being more effective in communicating.

Each theme identified consists of various sub-themes that emerged from parents’ accounts during the focus group discussions (FGDs). The sub-themes will be discussed in detail under each main theme in the analysis that follows.

Parents' current approaches to parent-child communication on sexuality

The parents that were part of the study in all four FGDs expressed varying levels of current communication with their adolescent children on issues of sexuality. While there were marked differences in some aspects of current approaches across the four groups, there were also many similarities. This investigation into parents' current approaches revealed some patterns, namely that parents are engaging in some communication, but it is (a) one-way communication, (b) is highly gendered, (c) consists of warnings and vague threats, (d) it is triggered by television, radio or news, (e) is selective. Parents also reported that they wait to see signs whether their adolescent child is sexually active or not before engaging in communication with them. All parents in the study were open to communicating about some topics, but not others. These overall patterns have been developed into more specific sub-themes, which are discussed with supporting data below.

Adolescents do not reciprocate communication by parents

One of the findings with respect to the nature of parents' communication currently, was that it is largely unidirectional, meaning that it is characterised by parents talking and adolescents listening. Parents expressed concern at the fact that when they initiate conversations, their adolescents are not keen to engage in such discussions, but prefer to remain silent, resulting in communication that is unidirectional from the parent to the adolescent. This was found to be consistent across all four focus groups.

"Ok, normally whatever I have said to her – she has never asked me a question. That's what worries me from time to time, because she has never asked me anything. I'm the one who is always talking."

(Older Urban mother, Queensburgh, July 2017)

"I have an 18 year old. We do speak but what I have noticed is that I tend to speak more than her. I do not know whether she is afraid of me or what. I do not know if it's because I scold her and I beat her. Maybe it is because of that, I do not know. I can see that she is afraid of me."

Maybe it is because of the way I speak about things or the way I handle things. Talking... we do talk but I can see that she is not free to talk to me in the way that I think she should be open to."

(Younger Rural mother, Umnini, June 2017)

There was a slight variation with this parent who expressed having tried to communicate, but felt 'awkward' talking with his son, and later abandoned communication altogether.

"It just became an awkward conversation with us, driving in the car, because I drive him to school and back every day, so I thought I would use this chance with just the two of us, without his mother. I was thinking that maybe this would help him open up more, but it was just worse. I didn't know if he was wondering what is this that dad is talking about now (laughter)...but we talked a bit, and I saw that he is now at that stage where he is not comfortable to talk about these things."

(Younger Urban father, Queensburgh, July 2017)

This finding contests findings from other studies, where parents expect their adolescents to listen while they talk, and do not encourage a dialogue with their adolescents (Bastien *et al*, 2011). It is unique in the sense that parents in this study display a need for communication to be reciprocated by their adolescents, and express frustration when their adolescents do not engage in this way.

A possible justification for why adolescents do not engage even when their parents initiate such conversations may be gleaned from findings from two studies; one conducted with South African adolescents in Soweto (Soon *et al*, 2003), and another with adolescents in rural Tanzania (Wamoyi *et al*, 2010). In these two studies adolescents reported that they refrain from engaging in discussions on sexuality with their parents due to the usually hostile tone that parents adopt in such conversations and that they lacked trust in what they could say to their parents for fear of punishment.

This finding of silence and avoidance was similar for younger rural, younger urban and older urban parents. There were no age differences noted for this finding.

Silence and avoidance

While on one hand some parents reported making attempts at communication, there are parents who reported having no communication at all with their adolescent children.

“For me, it’s a real dilemma because I know that in her age (14), girls are starting to have boyfriends, but still I’m not sure if I open this kind of discussion, will I be encouraging her to also have a boyfriend, so I just have that hesitation with her of thinking – should I talk, should I not? We can talk about general stuff, but when she asks deeper questions, then I just disengage with her, and say that’s enough...”

(Older Urban mother, Queensburgh, July 2017)

A study by Namisi *et al*, (2009) with adolescents in Cape Town and Dar es Salaam also found that adolescents experience substantial silence from parents and guardians on issues of sexuality. They further assert that this might be viewed as a protective factor by parents who perceive parent-child communication on sexuality to have the potential to encourage earlier sexual initiation by their adolescent children.

The same study (Namisi *et al*, 2009) also found that silence by parents was associated with socio-economic status, with parents of lower socio-economic status communicating less than those of higher socio-economic status in the two South African sites. Older rural parents, who were of a lower socio-economic status in this study, also reported not communicating with their adolescents. This older rural parent reported feeling helpless and just watching his adolescent grandsons impregnating girls, and not knowing what to do about it.

“There is nothing that we can do or say. We just see a girl already pregnant or a boy already having impregnated a girl. There is nothing really that we can say. I have that bad luck. They are my grandchildren. My grandson now has two children but he is still at school and he does not have money to pay damages because he is still at school.”

(Older Rural grandfather, Umnini, June 2017)

Other parents who reported not communicating stated that this was because of the belief that their adolescents were still too young (this particular parent's son was 12 years old), and they still had time.

“Absolutely not! It never even crossed my mind. Maybe it's because I think I still have time...(laughter by all participants)...because the older one is 12, but I think, errr, the 12 year old is a sponge for information, so I'm kind of threatened that already he has researched, because he likes to research and teach himself things.”

(Younger Urban father, Queensburgh, July 2017)

This finding was made with parents in another study by Wilson *et al* (2010), although there were no specifics given as to the age that parents regarded as 'too young'.

This finding of silence and avoidance by parents was found in reports by individual parents in all four FGDs. This could point to the need for parents to be capacitated to initiate communication on sexuality. Some evaluation studies of parent-child communication interventions in South Africa have shown that when parents receive an on-going intervention over time, their motivation and skills are improved, resulting in clearer messages and communication styles that are less aggressive and manipulative being used (Bhana *et al*, 2004; Phetla *et al*, 2008).

Parents use fear tactics, threats and warnings

Parents' accounts of their communication with their children also revealed that communication on sexuality with their adolescent children is characterised by the use of fear tactics, threats and warnings, ranging from pregnancy, HIV and even death. The following is an account by an older rural mother:

"I sit them down and tell them that growing up today has many challenges and that things are bad out there. I tell them that there is HIV/AIDS and that they should not fall to the dangers of HIV/AIDS like their parents and that they should not follow in the footsteps of their parents because they will also get infected with HIV/AIDS and they should try and look after themselves. They should look after themselves and listen to me."

(Older Rural grandmother, Umnini, June 2017)

Other similar strategies employed by parents in communicating with their children on issues of sexuality involve the threat of pregnancy, diseases and death as is seen in the following statements made by some of the parents.

"My child is a boy and one day he told me that he kissed a girl at school and I told him that he should stop that because if he continues, he will end up impregnating girls"

(Younger Rural mother, Umnini, June 2017)

"Our discussion is mainly around the fact that she must not get pregnant before she turns 16, she must wait until she gets married."

(Older Urban mother, Queensburgh, July 2017)

"I warn them and say that they should know that all girls are sick, they have diseases, and similarly all boys potentially have diseases and so they should not start sexual relationships until they finish their education and they are 21 years and they are adults. It is only then that they can start looking but until then, they should not have sex."

(**Older Rural** grandfather, Umnini, June 2017)

This finding on the use of threats, warnings and fear tactics was consistent amongst all four groups, showing no differences along age or location. It confirms findings in other studies (Kamangu *et al*, 2017; Nambambi & Mufune, 2011; Wamoyi *et al*, 2010) where both parents and their adolescent children reported parent-child communication on sexuality as being characterised by threats and vague warnings, mostly triggered by negative events such as pregnancy in neighbours or relatives' children.

There was a slight variation observed in a younger urban parent's account of how she has made her two daughters sign an agreement on paper that says that they will not have boyfriends until they are 18 years of age.

"...so I made them sign an agreement which says that is what they will do. So it says 'me, so and so, I promise that I will only have a boyfriend when I am 18 years old'. So I told them that I would keep this agreement. If I see that they are now starting to be troublesome before the age of 18 that will be my permission to discipline them."

(**Younger Urban** mother, Queensburgh, July 2017)

This shows an effort towards some negotiation for the setting of sexual parameters between the parent and her daughters, a finding that was not mentioned in other studies, but which is interesting as it indicates parental agency in ensuring positive SRH outcomes for adolescents. This finding confirms the CCA's stance that cultural participants are not just active bystanders, but are active agents in ensuring positive health outcomes for themselves and their communities (Dutta, 2008).

Communication by parents is highly gendered

A significant number of parents in this study related current practices in communication on sexuality that revealed that their communication was highly gendered in two ways. Firstly, communication with girls was mainly to discourage them from having sex, while the opposite applied for boys.

Secondly, mothers communicated more than fathers. Each of these gendered aspects of communication will be discussed further below.

Conflicting messages for girls and boys

Older rural parents talked about the practice of virginity testing frequently, saying that they encouraged their adolescent girls to go for virginity testing because they believed this would discourage the girls from engaging in sexual activities.

“They go all the time for virginity testing. I tell them that I am very happy about it because I can see that they are preserving their virginity and that they are not going to get pregnant and bring children at home because I told them I had them when I was married and they should do the same and have children once they are married and not at their home.” (Older Rural mother, Umnini, June 2017)

In yet another instance a parent related that she had a conversation with her adolescent son who told her that he had sexual intercourse with a girl and then bled, to which she replied that it probably was a sign of growing up. When the researcher asked if her reaction would have been the same if it had been her adolescent daughter relating the same story, the following discussion ensued:

Interviewer: “Can I ask this question? You said earlier on that your boy told you that he said he bled when he had sex with a girl and you said to him it means he is growing up. If this were your daughter telling you that she slept with a boy and now she is bleeding, what would you have said?”

(Crosstalk – apparent shock at the question by all parents)

Participant 4: “I was going to faint.” (Laughing)

Participant 6: “I was going to tell her that it is wrong and she is wrong. This (sex) is for older people and not for children.” (saying it quite disapprovingly) (Younger Rural FGD, Umnini, June 2017)

So, while this parent viewed sexual activity as permissible for her son, she held the opposite view if it were her adolescent daughter. This message from parents to their adolescent children, that sexual activity is dangerous for girls, but is an adventure for boys, was also found by Nambambi and Mufune (2011) when they had conversations with both adolescents and their parents in Namibia. Wamoyi *et al* (2010), in their study on Tanzanian rural parents' practices with regards to parent-child communication on sexuality, also found that parents tend to discourage sexual activity with girls, while encouraging it with boys. This was to the point where fathers were said to brag about their sexual prowess when growing up, while mothers would brag about their sexual innocence when growing up, which further entrenched this gendered view. This is a finding that points to a need for gender issues to be addressed in interventions for parents, since leaving these discrepancies unchallenged may be counter-productive in addressing unplanned adolescent pregnancy.

Mothers communicate more than fathers

A second aspect of this gendered communication relates to the fact that most of the communication was reported as being conducted by mothers for both boys and girls, and less so by fathers. This was a finding that was consistent across all four FGDs, and which has been observed in various African and Western contexts (Ballard & Gross, 2009; Akinwale, 2009; Emelumadu, 2014).

“With me, I do have a husband, but I’m the only person that talks with the kids. He just keeps quiet. He just sits with my daughter and they talk about other things – I was the one that spoke to her about puberty.” (Older Urban mother, Queensburgh, July 2017)

Some fathers also felt that communication on issues of sexuality was the responsibility of mothers, especially when they are younger.

“I think that in the modern days, it is okay for the young brides like yourself to speak to the boys and tell them about puberty because the

father is busy outside but you have the time because they are always in your space.” (Older Rural father, Umnini, June 2017)

Mothers communicate with girls and fathers with boys

An additional aspect of this tendency for gendered communication was in relation to the fact that mothers tended to communicate with girls, while fathers tended to communicate with boys.

“Well, I did speak to my boy about what he should expect growing up. I didn’t speak to my daughter – her mom had already spoken to her. So we were just talking about the body changes as he grows up, things like wet dreams and so on. So I told him that it’s natural, he must not be surprised when it happens.”

(Older Urban father, Queensburgh, July 2017)

Where a father reported having communicated with his daughter, he expressed that he was ‘forced’ to communicate due to the mother being away at the time.

“With puberty, I had an experience where I was forced to discuss that with my daughter because she started menstruating when her mother was away on business, and it was only me in the house, so she came to me and told me what had happened, so I had to re-assure her that there is nothing wrong. I went to the shops to buy sanitary pads for her, and explained what I know about menstruation to her, and she was fine after that.” (Older Urban father, Queensburgh, July 2017)

Mothers mostly felt that they found it difficult to communicate with boys because they did not fully understand the biological aspects of puberty for boys.

“Another thing for me is that since I am a single parent, it was easier with my daughter (now 22) because you understand your body and it’s much easier to explain something that happened with you as well. With

my son, as much as you read, but there are things that you just don't relate to because you never experienced them. It's much easier to talk about something that you know."

(Older Urban mother, Queensburgh, July 2017)

"Well, for me, I want information because as I said I only have boys, so I don't know anything about boys' bodies because I didn't even see anything with my brother."

(Younger Urban mother, Queensburgh, July 2017)

In the African cultural context, education on issues of sexuality has traditionally occurred along gendered lines, where female adults would address younger girls, and male adults would educate younger boys (Buthelezi, 2004; Delius & Glaser, 2002; Gumede, 1978; Hunter, 2004; Kayongo-Male & Onyango, 1984). The findings in this study, therefore, confirm this preference displayed by parents for mothers to communicate with girls, and for fathers to communicate with boys.

Parents are selective in communicating on issues of sexuality

The sexuality topics that were of interest in this study were puberty changes, intimate relationships and contraception. Parents reported that they communicated with their adolescent children on certain topics, but not on others. Some parents discussed puberty changes for boys and girls, although not all parents reported this. Most parents reported that this particular topic was much easier for them to discuss, as it is something that happens for everyone. Intimate relationships were also discussed by most parents, but with the aim being largely to discourage their adolescent children from engaging in them, rather than guidance on handling romantic relationships.

"For me, I think what is easier to talk about is the puberty changes because that is something that is already happening in her body, she is experiencing it, so it's much easier to talk about that for me, but maybe it's because my daughter is still 11...(laughter)..."

(Younger Urban mother, Queensburgh, July 2017)

“I don’t have that confidence...(laughter)...I just talk by the way, but not directly. I just always say to her that boys will always be there so you concentrate on your studies. I’ve never really gone deep to say this is what happens and so on.”

(**Older Urban** mother, Queensburgh, July 2017)

Contraception was the topic that was the most difficult for most parents to talk about with their adolescent children, and various reasons were provided for this. The most mentioned reason was that parents feared that talking about contraception with their children might influence them to start engaging in sexual activities earlier. Most parents were vehemently opposed to any discussion on contraception with their adolescents.

“What has surprised me is what I heard that they are teaching them at school about contraception. I do not know why they would encourage contraception at such a young age?”

(**Older Rural** mother, Umnini, June 2017)

“When you tell them to use contraception, you are giving them freedom to go around having sex.”

(**Older Rural** father, Umnini, June 2017)

“Maybe with HIV and AIDS, one can talk about that and warn children about possible infection if they don’t stay away from sex, but contraception is not easy to talk about because it’s like giving your child permission to have sex when she is still too young. So, yah, we talk about many other things with my daughter, I ask her what she thinks, what she knows, but I don’t want to be the one that introduces contraception” (**Older Urban** father, Queensburgh, July 2017)

Where parents communicated with their adolescent children on contraception, it was only after they had fallen pregnant, and the motivation was to avoid further pregnancies.

“My daughter started contraception when she was much older. I would say to them that a person should look after herself and explain to them how they should behave and what to do. But when they got pregnant, I encouraged them to start using contraception so that they would not continue to bear children and have many children.”

(Older Rural mother, Umnini, June 2017)

“Because our culture does not promote having sex at a young age and so speaking about contraception to them is like advising them to choose a way that is not right. We are afraid to go against culture. We only say it if you see that she has gotten pregnant and then tell her to use contraception.”

(Older Rural mother, Umnini, June 2017)

In all four FGDs conducted with parents, only two parents reported communication with their daughters on contraception. One parent reported that it was her daughter that asked about contraception, so it was not voluntarily communicated. Even with this communication, the mother related how she spent considerable time answering her daughter's questions in a way that would discourage her from using contraceptives.

“What brought that about was that she (daughter) came to me and asked me...so she asked me what do I know about contraception...I must confess, though that even now, I don't know whether to say yes or to say no to contraceptives because I've spoken about my belief system and why I don't think she should use them.”

(Younger Urban mother, Queensburgh, July 2017)

The above example of adolescent-initiated communication was rare, and where it happened it was always as a result of what adolescents had learnt in school. It is evidence of how the environment within which people live impacts on individual behaviours and actions, as understood by the SEMCHB framework.

In contrast to the majority of parents who were opposed to discussing contraception with adolescents, some parents highlighted their belief in the need to talk openly to daughters about contraception.

“So with my daughter, I want her to know that she can go for contraception, as long as she knows that she is sexually active, even if she’s an active member of the church. I just want her to know that she can freely use it if she is having sex so that she knows that even mama is fine with it, so even when someone I know tells me that I saw your daughter at the clinic, she will not be worried about me finding out.”

(**Younger Urban** mother, Queensburgh, July 2017)

As is apparent from the account above, the mother’s stance on contraception is influenced by her experience of having fallen pregnant at the age of 19 years, due to the fact that she was afraid to go to the clinic, as she feared being scolded by the nurses. In the study by Wamoyi *et al* (2010), one parent who had reported having encouraged her daughter to use contraception was the one whose adolescent daughter had reported that she had never had sex. So, while parents may perceive that communication about contraception will encourage earlier onset of sexual activity, the opposite may apply. This confirms the finding that despite beliefs to the contrary, open communication with adolescents about contraception does not lead to earlier onset of sexual activity, but instead leads to its delay (UNICEF, 2013).

In the FGDs with rural parents, there was a marked cultural influence in terms of how they viewed communication on contraception. The Zulu cultural custom of *ilobolo* (bride price), featured significantly in parents’ discourses on contraception. The cultural practice of *ilobolo* requires that the bridegroom pay a cow that acknowledges that he will be taking the bride’s virginity once they are married. It is the parents of the bride that normally request this payment during *ilobolo* negotiations. Where this is practiced, parents are always weary of requesting this payment when they are not sure whether their daughter is still a virgin or not. It is therefore regarded as a shame to the family if the

bridegroom is requested to pay this fee when the bride is no longer a virgin. Older rural parents' perceptions of communication on contraception were therefore largely influenced by this concern.

“What I am afraid of is that when she gets pregnant and the one who has impregnated her is expected to pay for having taken away her virginity when in fact she has been sleeping around and not getting pregnant because I was encouraging her to use contraception. That is not being truthful as parents and it goes against our culture.”

(Older Rural mother, Umnini, June 2017)

“We were saying that we are afraid to encourage our girls to use contraception because when she gets married and you ask for the full ilobolo knowing that she has been using contraception and sleeping with other men, that is wrong.”

(Older Rural mother, Umnini, June 2017)

The above finding on the cultural practice of *ilobolo* influencing parents' communication about contraception had not been found in other similar studies. Studies with rural parents elsewhere showed that rural parents were equally reticent to discuss contraception with their adolescents, but this lack of communication was related to restrictive gender and cultural norms in general, and not to specific cultural practices as found in this study (Izugbara, 2008; Wamoyi *et al*, 2010). It is a finding that is in line with the CCA, which “seeks to introduce the voice of the local communities into the ways in which issues of health are understood, interpreted, and communicated” (Dutta, 2008:60).

Using the media to facilitate parent-child communication on sexuality

When asked about aspects that trigger discussions on issues of sexuality with their adolescent children, parents reported that some discussions start as a result of what they see on television, what they hear on the radio, as well as

other news that may come from main news media channels or other events that may happen at work or in the community.

“For instance you can start by recalling what you have been watching on TV the previous day and you can say to her, what is it that you would like to know from what you were watching yesterday?”

(**Younger Rural** mother, Umnini, June 2017)

“Sometimes it happens that when you look at things, especially things that we see on TV, things that are talked about or even things that happen, then you start talking with them.”

(**Younger Urban** mother, Queensburgh, July 2017)

“I sometimes see things that are happening at work (clinic) and then I talk to her.”

(**Older Urban** mother, Queensburgh, July 2017)

“What helps me with my daughter is that she sometimes has friends over at my house and they watch TV together, so when something comes up on TV, I encourage them to talk about it, and we have a discussion about it. That helps them to open up and not shut you out as a parent.”

(**Older Urban** mother, Queensburgh, July 2017)

The above finding was prominent among younger urban parents, older urban parents, and younger rural parents only. Older rural parents did not report using opportunities presented on the television, radio and other media to initiate communication on sexuality.

Factors that influence parent-child communication

When parents related their experiences with parent-child communication on sexuality, several factors emerged as having an influence on what they communicated about, as well as how they communicated with their children. The parents' own upbringing was one such influence, with culture, religion,

socio-economic and educational background, as well as access to information, also showing an influence in parents' experiences and practices regarding parent-child communication on sexuality.

The influence of upbringing on parent-child communication on sexuality

All the parents, in all four FGDs, reported never having open communication with their parents on issues of sexuality. Their experiences with their own parents were varied, ranging from silence to scolding and severe beatings if they suspected the adolescents of being sexually active. When parents were asked about the nature of their communication with their parents, the question raised laughter and shaking of heads mostly, giving the impression that this was something that was unheard of. One parent reported being told by her mother that since she had started menstruating, she should run away from boys, and she said she didn't understand what this meant at the time. The following were some of the parents' reports on this issue.

"As for me, I was told since that since you have started your periods, if you sleep (with a boy), you become pregnant! – Even when I came home a bit late from school, my mom would shout at me and say "you have a boyfriend now? You have a boyfriend now?"

(Younger Urban mother, Queensburgh, July 2017)

"There was no communication. There was only discipline. We were beaten and that's all... When you came back from school late, beating... when you were seen walking along with a boy, beating and when you were seen mimicking what you saw on TV, beating. They talked to us through beating."

(Younger Rural mother, Queensburgh, July 2017)

There were few parents who reported different experiences of having had some communication with their parents in the older urban FGD, and one said this was because her mother was a biology teacher.

“For me, luckily my mother was a biology teacher, so she would talk to me about these things all the time.”

(**Older Urban** mother, Queensburgh, July 2017)

The above could be related to findings in a study conducted by Kaufman, , Clark, Manzini & May (2004) in KwaZulu-Natal, South Africa, where there was a positive correlation between household members’ education and adolescents’ sexual risk avoidance. The study by Kamangu *et al*, (2017) in Kenya, Uganda, Rwanda and Tanzania also found that in all four countries, educated parents were more likely to engage their adolescents in discussions on sexuality.

Some parents reported that that they attended holiday programmes where they were educated on issues of sexuality, and her conversations with her mother would be about their mother asking them about what they had learnt, and the conversations would start in that way.

While for some participants, this lack of open communication with their own parents encouraged them to make efforts to communicate, for others it became a stumbling block that prevented them from communicating with their children, as they reportedly did not have an example to learn from. For one parent, her negative experiences with her own mother were now a barrier for her to communicate with her own daughter.

“For me, it’s so difficult, you know, sometimes I fear that I’m responding to my daughter in the same way that my mother did to me. She always shouted at me and never explained things properly – and so I just decide to shut up and not continue with a discussion anymore.”

(**Older Urban** mother, Queensburgh, July 2017)

Other parents, however, reported being purposeful about communicating with their own children because they did not want to repeat the mistakes their parents made. Some acknowledged that even though their parents’ harsh

methods helped them delay the onset of sexual activity, they still felt that those methods were out-dated and the changed times required new ways of behaving for them as parents.

The interplay between parents' own experiences when growing up, and their current parenting methods, is a phenomenon that has been found in other studies as well. Studies by Kuo *et al* (2016), Vilanculos and Nduna (2017), both conducted in rural and urban areas in South Africa have also revealed similar findings where parents report having had no communication with their own parents when growing up. In the South African context, and in other studies in other African countries (Akinwale *et al*, 2009; Mbugua, 2007; Nambambi & Mufuna, 2011), parents report not communicating with their adolescents as a result of this residual effect, whereas in this study, urban parents, in particular, report being motivated by this to do better with their own adolescents, a finding that was also made in a study in Ireland (Ballard & Gross, 2009).

In this study, it was younger rural, younger urban and older parents who reported being conscious of not repeating their parents' mistakes. Older rural parents reported not communicating since they also received no communication. However, it must be stated that with regards to some older rural parents, there emerged a pattern that was markedly different. These parents reported very low to no communication on sexuality with their adolescent children and grandchildren, but reported having experienced more open acknowledgement of sexuality by their parents. While the parents reported having no communication with their own adolescents on sexuality, they told stories of elaborate discussions with their own parents around puberty changes for boys, including traditional circumcision practices.

"I have never heard my boys talking about dreaming sleeping with an old woman (referring to a wet dream) but I did hear from my father advising my brothers about all this. My father would say to my brothers, once they have had a wet dream, they should not come close to girls

*and they should not be lazy and sleep but rather do the house chores.
And I would see my brothers doing as they were told.”*

(Older Rural mother, Umnini, June 2017)

Despite this however, older rural parents felt that the times have changed and that their children learn new things from school and the broader social environment, and so tended to place less value on what they know from their cultural background. Older rural fathers, in particular, expressed a sense of helplessness with their adolescent boys, saying that they do not engage in any communication with them, but rather watch helplessly as they impregnate girls.

This finding may already allude to culture-centred theorising that asserts that lack of engagement with marginalised communities often leads to the “silences and absences” of authentic community voices from the mainstream discourses on health (Dutta, 2011:9).

The influence of culture on parent-child communication on sexuality

Parents’ accounts of their experiences and perceptions of parent-child communication on sexuality often revealed a strong cultural influence. This was prominent among rural parents. Older rural parents expressed their reliance on cultural practices as a way to ensure that their adolescent children did not engage in risky sexual behaviours. Virginity testing was often mentioned as a practice that they encouraged for girls. This older rural mothers were particularly proud of their daughters who go for virginity testing.

“I like it because they chose well because they chose to go for virginity testing. They go all the time for virginity testing. I tell them that I am very happy about it because I can see that they are preserving their virginity and that they are not going to get pregnant.”

(Older Rural mother, Umnini, June 2017)

Some older rural parents made references to “ukusoma” (thigh sex), as a pregnancy prevention method that they communicated to their adolescent boys, although they felt that boys do not take this advice, hence the high levels of pregnancy that they were seeing amongst their own children. Older rural parents objected to communication on contraception with their adolescent children based on the fact that they perceived such discussions to be against their culture.

Interesting to note, however, is the account of one older rural mother who related how she cautioned her daughters about the need for them to be responsible for their own bodies as she realised that her daughters could be saying they are going for virginity testing while they are not.

“I was trying to protect my kids and myself. I do not know whether it is right. I know that it is not safe for our kids. Even in our very houses they can get pregnant and even on the way to get tested or coming back. They can get pregnant. It is really very difficult to police them. We can go on and blame the tester and say she did not do her job but find that it is my child who did not go to the testing or did not go to school or went to school but stayed in the toilets. We do not know what our children are up to if they are out of sight. In other words I am saying that they should be responsible for their own behaviour and take responsibility for their sexual health.”

(Older Rural mother, Umnini, June 2017)

Evident in this mother’s account is her ability to reflect and critically evaluate her stance or belief in virginity testing, and the realisation that changed times call for further action on her part (communicating with her daughters), and not just reliance on virginity testing. It is an account that shows the mother’s agency when she realises that her strategy of sending her daughters for virginity testing might not be relevant anymore, and therefore the need for new terms of engagement with her adolescent daughters.

While on the one hand older rural parents' accounts of their experiences was largely influenced by their cultural background and beliefs, urban parents on the other hand reported being wary of cultural practices and beliefs. One older urban father reported that he is selective when it comes to cultural practices and beliefs, and so he picks and chooses that which suits him and the values that he wants to impart to his children.

"You pick and choose, really, what suits you, especially when it comes to cultural values. You look at what works for you as a family, you know, what is comfortable for you and your family...so really this thing of cultural beliefs, I think it is up to each family to decide what works for them and what doesn't."

(Older Urban father, Queensburgh, July 2017)

Another father, in the younger urban FGD, expressed being challenged by the cultural value of 'ubusoka' (a ladies man) that is part of his upbringing, and was conscious of the challenge that it posed for him in communicating with his adolescent boys on issues of sexuality.

"I foresee a challenge because the culture that I come from favours a boy more than a girl. So, what boys do can be tolerated; we come from a culture that praises "ubusoka" (being a ladies man)...the culture that we come from tends to promote that thing that boys can mess around, but not girls. It's going to be a challenge for me to teach my boys."

(Younger Urban father, Queensburgh, July 2017)

In a study exploring the effects of a culturally adapted parenting intervention for American Indian families, Kulis *et al*, (2016) state that in the urban environments American Indians who had moved from rural environments were found to be torn between maintaining their cultural values and adopting mainstream behaviours associated with urbanised environments. As a result, many of them had acculturated and embraced mainstream cultural values and parenting styles. A similar phenomenon can be said to be at play with the urban parents in this study. Mbugua's (2007) study with Kenyan mothers also

found that urban educated mothers abandon cultural values and practices and instead adopt a hybrid mix of cultural and Christian values.

The influence of religion on parent-child communication on sexuality

The findings of this study revealed that religion, and in particular, Christianity, played a significant role in influencing the nature of communication between parents and their adolescent children. Parents frequently referred to Christian values as what guides their discussions on sexuality with their adolescent children.

“We talk about the fact that they should be able to look after themselves...that a child must go to church because if he or she does not go to church there are a lot of things that can go wrong because you hear a lot of things out there that may be misleading and also if you are a child who likes to go out with friends, there are lot of bad influences that this can bring in your life.”

(Older Rural mother, Umnini, June 2017)

In the older urban FGD, parents expressed a desire to ensure that what they communicated with their children was based on Christian values. An older urban single mother of a 16 years old boy talked about how she has considered asking her doctor to talk to her son about puberty changes, but hesitating because of not knowing “how far he is going to take it, and also the fact that he’s also not a Christian doctor”. When relating a discussion that she had with her adolescent son on masturbation, a younger urban mother also related how she impressed upon her son “to look at what God says about it” first, before making a decision whether to do it or not.

In the older rural FGD, parents repeatedly expressed how they try to get their adolescent children and grandchildren to go to church because of the belief that church teaches values that discourage early sexual activity.

“It is good if a child goes to church because many bad influences do not affect her and also a child who is always going out with friends gets corrupted because they can influence her wrongly whereas in church they promote good values and the Bible provides a good basis for them to be able to know what is wrong and right. Even the elders in church advise them but a child that does not go with her parents to church gets left out. You will hear the difference in what they talk about. Those that attend church are constantly exposed to an environment that promotes good values.”

(Older Rural mother, Umnini, June 2017)

When they were asked what support they felt they needed in order to initiate and maintain communication on sexuality with their adolescent children, parents also expressed a need for the support to not only include biological information, but also information that is in line with their Christian faith.

“But more than being just biological, I would like it (information) to be matched with Christianity because that is where our values are based. So if we can get the chance to support everything we teach them with our belief in God that would have more weight on them more than any other thing. So, for me, it must mix biology with my faith.”

(Younger Urban mother, Queensburgh, July 2017)

Other studies before have simply noted a negative correlation between the religiosity of parents and parent-child communication on sexuality (Kamangu *et al*, 2017; Namisi *et al*, 2009; Regnerus, 2005). Parents in this study, however, do not express being hindered by their religious beliefs, but rather seeking ways in which they can match the content of discussions with their religious beliefs.

Access to resources and information on sexuality

Parents often mentioned the lack of information as a contributing factor that limited their ability to communicate effectively with their adolescent children on sexuality. Parents in all four FGDs expressed the need for more information in

order for them to be able to communicate effectively with their children on sexuality. However, urban parents in both FGDs reported having more access to information and resources than rural parents.

Urban parents frequently reported having used the Internet, books and media resources such as television and radio to educate themselves so that they could communicate effectively with their adolescent children.

Younger Urban mother: *“Some of it you get from books...from books, yes, some on radio, sometimes when you watch educational programmes on TV, so that’s how we get information.”*

Younger Urban mother: *“I had to look for some of it, especially because when I was growing up I didn’t get it, so I went and looked for a book that explains everything about menstruation.”*

(**Younger Urban** FGD, Queensburgh, July 2017)

Some parents reported providing books and access to the Internet for their adolescent children so that they could find information themselves.

Older Urban mother: *“It’s books mostly – sometimes I just give books to read and she reads by herself.”*

Older Urban father: *“I also give them tasks at home and say they must do their own research, maybe on HIV/AIDS and so on. So I give them books to read and I give them my phone and tell them to search the Internet for information. I tell them to write things down and then to tell me what they found.”*

(**Older Urban** FGD, Queensburgh, July 2017)

Where parents reported not communicating with their children, they acknowledged that this was due to neglect on their part, and not because they lacked access to information.

“I think even my lack of knowledge is because of neglect by myself as a parent because I think there’s a lot of information out there. All we

need to do is ask, and if we don't know, we have people we know who are doctors.”

(Younger Urban mother, Queensburgh, July 2017)

The situation was slightly different with rural parents, as none of them reported having access to books, the Internet, or other similar resources. The only source of information that was reported was community-based organisations that work on issues of sexual and reproductive health and HIV/AIDS.

“We do have information. We get it from DramAidE (an NGO), Faith and Hope (a CBO), from the clinic...”

(Younger Rural mother, Umnini, June 2017)

However, even with the presence of such organisations at community level, it was clear that these interventions do not reach all parents equally because while some rural parents reported having learnt about sexual and reproductive issues for young people, some also displayed a lack of basic information around menstruation.

“I just say to my daughter the rat has beaten you if she starts menstruating. I do not know how it happens biologically and I cannot explain it to her.”

(Younger Rural mother, Umnini, June 2017)

Younger rural parents mentioned clinics, NGOs and CBOs as additional sources of information where they get information on sexual and reproductive health, but this was not mentioned by older rural parents. The majority of older rural parents either had low education levels or no formal education at all, and so the likelihood for them to be able to access information by themselves was highly reduced. This difference between urban and rural parents provides insight into structural factors that influence parent-child communication on sexuality.

Adolescents avoid communication with parents

Parents reported experiencing difficulty in communicating with their adolescent children due to the fact that their children avoid attempts that they make at communication. Adolescents were said to avoid attempts at communication in various ways, including twisting parents' words and avoiding communication. Some adolescent children were said to ward off communication by saying that they are virgins, and do not need warnings about boys because they are not sexually active.

"When I try to start such conversations with my grandchild about these things, she shuts me out by saying 'those things are not for me - I am a virgin and I am not having sex' and then I do not continue with such discussions but tell her that I am watching her to see how she behaves."

(Older Rural mother, Umnini, June 2017)

"Even when you think that there is an opening, these kids are very clever; they will just twist your words and avoid talking about these things."

(Younger Rural mother, Umnini, June 2017)

Other parents reported that their adolescent children accuse them of talking too much, while others just naturally withdraw from conversations with their parents, as they grow older. Parents state that this constant blocking of communication by their adolescent children discourages them from starting conversations, and so they end up not communicating with them.

This finding has been made in other studies conducted in Limpopo province, South Africa (Phetla *et al*, 2008), where mothers who were part of the *Sisters for Life* intervention aimed at improving communication on sexuality between parents and their adolescents, reported that their adolescents put up a 'know-it-all' attitude, which prevented them from communicating with them.

Perceptions of parents on parent-child communication

The perceptions of parents on parent-child communication on sexuality were varied, but mostly positive. Urban parents mostly felt that they should be the first to introduce sexuality education to their children, and not the school, while rural parents displayed an over-reliance on the school and other institutions to educate their children on issues to do with sexuality. All parents also felt strongly that communication on sexuality should be values-driven. While the school was viewed as supportive of efforts to educate adolescents on sexuality, it was simultaneously viewed with suspicion and not to be fully trusted. Parents also felt that they needed support in initiating and maintaining sexuality communication with their adolescent children, as they expressed that adolescents sometimes block their attempts at communicating.

Perceptions on the role of parents in communication on sexuality

When asked whether they thought parents should communicate with their children on issues of sexuality, urban parents reported that parents should indeed be at the forefront of this communication and that they should be the first to communicate to their children about sexuality.

“In fact, even before the school does, it should be the parent that starts.”

(Younger Urban mother, Queensburgh, July 2017)

With urban parents, this belief was based largely on the expressed need to have control over what their children learn, how they learn it, and when they learn it. Urban parents justified this need in various ways, including lack of trust in government schools and other institutions to promote the same values that parents hold dearly, as well as the general mistrust of ‘outsiders’ when it comes to beliefs concerning sexuality.

“How do I trust the government that is now proposing to distribute condoms in schools... that legalises abortions? So, we have to be the first to teach as parents, and the family principles must be uppermost in that teaching.”

(**Older Urban** father, Queensburgh, July 2017)

“There are too many crooks out there. I’d rather do it myself, and then I know that the best interests of my child are taken care of in that way.”

(**Older Urban** mother, Queensburgh, July 2017)

While the overall sentiment expressed by urban parents was that parents should be the primary educators, there were some who admitted to having neglected this aspect of communicating with their children due to knowing that their adolescent children were receiving this education at school and/or at church.

“I think with the one who is 12 years old, they cover that part at Sunday school – I’ve heard something to the effect that that’s what they learn, but then when it comes to me, I haven’t really thought about how do I start – how do I address these issues of sexuality with him, especially since he is a boy child.”

(**Younger Urban** mother, Queensburgh, July 2017)

However, there were marked differences between rural parents and urban parents in this regard. In contrast, rural parents in both FGDs tended to trust the school and other institutions like the church and community-based NGOs to perform this function on their behalf, as the following conversation in the older rural FGD illustrates.

Older Rural mother: *“There is nothing that my mother told me when I got into puberty, I had heard about it because we were taught at school. The school nurses visited our school and taught us about puberty and they gave us sanitary pads.”*

Interviewer: *“What about your own children?”*

Older Rural mother: *“I do not speak to them because the health nurses also visit their school and tell them about menstruation and give them pads.”*

Interviewer: *“So you hold on to the hope that they are taught about it at school?”*

Older Rural mother: *“Yes, that’s the hope we have and you can actually see them coming home with the sanitary pads.”*

(Older Rural FGD, Umnini, June 2017)

There was one parent in this group who objected to this and related that she actually talks to her daughter herself, but when asked about what sparks their discussions, she also said it was sparked by her daughter asking questions after they had been taught about menstruation at school. Older rural parents also employed other strategies like encouraging church attendance and virginity testing for their adolescents, with the belief that it’s these structures that can better ensure that their adolescents do not engage in risky sexual activity.

Younger rural parents similarly placed greater importance on the role of the school and other community-based organisations to communicate with their adolescent children on issues of sexuality. Their view was somewhat different from that of the older rural parents in the sense that they felt that these institutions, rather than taking over their role as parents, they instead play a significant role in initiating these discussions, and this, in turn, makes it easier for them to then communicate with their children.

“We talk to our kids but the schools and community organisations play an important role and this makes it easy for us as parents to talk to our children because they are first provided with this information that is correct and this is good.”

(Younger Rural mother, Umnini, June 2017)

The findings emanating from this study on beliefs around the role of parents is not unique to this study. Parents in other studies in South Africa have also confirmed the primacy of their role as communicators of sexuality information with their adolescents (Kuo *et al*, 2016; Namisi *et al*, 2009; Soon *et al*, 2003; Vilanculos & Nduna, 2017).

No studies in the South African context have reported the over-reliance on school and external organisations by parents. It is in a study in Ireland (Abbey, Drennan, Butler, Howlett, Carney & Lohan, 2013) where a similar finding was made, where parents were found to be complacent in communicating with their adolescent children due to the reliance on in school programmes to perform this function. More recently, Kamangu *et al*, (2017) in a study with East African parents, and Vilanculos and Nduna (2017), in a South African study, noted that the educational level of the parent significantly affected whether parents communicated with their children on issues of sexuality or not, with higher education levels associated with more frequent and more open communication, and the inverse being true for parents with lower educational levels.

Although educational levels were not under scrutiny in this study, urban parents had predominantly higher levels of education than rural parents, with the majority of older rural parents having no formal education at all. This finding may therefore, be linked to this aspect of educational level, although it was not investigated how this influences perceptions by parents.

Perception that communication promotes earlier onset of sexual activity

All the participants in all four FGDS voiced the concern that parent-child communication on sexuality may result in promoting earlier sexual experimentation by adolescents. Parents that reported not communicating with their adolescent children mentioned that their reluctance to communicate was based on this fear. Parents who reported having made attempts at communicating with their adolescent children indicated that they carefully selected topics to discuss based on this fear that some topics (mostly on contraception) may lead to earlier onset of sexual activity.

“The problem about it is that they may want to go and experiment and that’s where the danger may be about telling them too much information too early without them having the maturity to know what is wrong and right.”

(**Younger Rural** mother, Umnini, June 2017)

“For me, it’s a real dilemma because I don’t know if by encouraging openness I am encouraging her to start being sexually active early, also if I don’t talk with her, then what will be the result.”

(**Older Urban** mother, Queensburgh, July 2017)

“The challenge for me is that sometimes you think you are doing your job, but you find that you are now moving ahead of the child to things that she or he is not yet ready for, and you may end up providing the impetus for your child to explore.”

(**Younger Urban** mother, Queensburgh, July 2017)

The above finding is common amongst several other studies that have been conducted on this issue, both in the African and Western contexts (Miller, 2002; Wamoyi *et al*, 2010; Wilson *et al*, 2010).

Parents’ strategies for becoming more effective in communicating

Parents in all four FGDs were able to state what they felt they needed in order to be able to engage in meaningful and effective communication on sexuality with their children.

Platforms for learning

The overall differences in terms of what platforms for learning parents felt they needed were between rural and urban parents. Rural parents in both FGDs stated that they needed support groups where they could meet regularly as parents to discuss how they could effectively communicate with adolescents on issues of sexuality. Preference was also given to face-to-face information sessions or workshops that they thought could be provided by organisations in their communities.

Whilst some urban parents preferred web-based platforms like social media for the sharing of tips and information, some felt that such platforms could be

time-consuming and difficult to keep up with. They preferred face-to-face interactions with 'skilled' people on issues of adolescent sexuality. While all parents mentioned parents-only workshop sessions as a preferred platform for learning, some older urban fathers stated that they wished for platforms where both parents and children would learn together, to ensure that discussions would carry on even when they got home.

"I would also love a programme that includes both parents and children together. It could be in the form of games and so on, but as long as it provides the opportunity to engage us both and we get to practice these discussions there and then, because when you receive an intervention as a parent, and then have to go home and practice what you learnt, you will still hesitate to start the discussion, so it's better if both of us are there in one session, and it encourages both of us to be free and we do this in a playful manner. When programmes keep us separate, we will still have problems of struggling to use what we learnt."

(Older Urban father, Queensburgh, July 2017)

Conclusion

This chapter presented an analysis of the data that were collected through focus group discussions conducted with four sets of participants. The data show reveal four main themes and sub-themes as follows:

- 1) Parents' current approaches to parent-child communication on sexuality.
 - a. Adolescents do not reciprocate communication by parents.
 - b. Parents avoid discussions on sexuality.
 - c. Parents use fear tactics and vague warnings when communicating.
 - d. Communication by parents is gendered.
 - e. Communication by parents is selective.
- 2) Factors that influence parent-child communication on sexuality.
 - a. Parents' upbringing influences communication on sexuality.
 - b. Culture influences communication on sexuality.

- c. Religion influences communication on sexuality.
 - d. Access to resources and information influences communication.
- 3) Parents' perceptions of parent-child communication on sexuality.
 - a. The parent's role in parent-child communication on sexuality.
 - b. Parents fear that communicating will result in earlier sexual debut amongst adolescents.
- 4) Parents' strategies for being more effective in communicating.
 - a. Platforms for learning.

Chapter six will present a detailed discussion of the findings and relate these to the objectives of the study and the theoretical framework applied in the study.

CHAPTER SIX - DISCUSSION OF FINDINGS

Introduction

This chapter presents a discussion of the findings, as they relate to the study's objectives and research questions. The findings are also discussed in the context of the theoretical framework applied to this study, the Culture-Centred Approach by Dutta (2008) and the SEMCHB by Kincaid *et al* (2007).

Objective 1

To establish if parents are communicating with their adolescent children on issues of sexuality and to establish the nature of this communication (if occurring)

The first objective of this study was to investigate the nature of parent-child communication on sexuality amongst four groups of participants (parents); younger rural, older rural, younger urban and older urban parents. Findings of this study revealed that in some cases, parents were engaging in what they believed to be communication on sexuality, albeit at different levels. The focus on the communication reported was on discouraging sexual activity, more than on relaying concrete biological or relational information. What parents communicated can largely be attributed to the communication of values around sexual activity, which were mainly framed around cultural and religious appropriateness.

Communication on contraception was avoided, and communication on intimate relationships was largely to discourage the formation of such relationships. Pubertal changes for boys and girls was the most talked about topic, with differences noted between older rural parents and the rest of the parents involved in this study. Differences that were noted amongst the groups were that some younger rural, younger urban and older urban parents reported making some attempts at communicating about pubertal changes for both boys and girls, in contrast to older rural parents who reported not communicating about these biological aspects at all. Urban parents reported making use of books and the Internet to educate themselves so that they could, in turn, educate their adolescents on pubertal changes. Younger rural

parents reported relying on community based organisations (CBOs) and NGOs working on issues of SRHR, and reported gaining knowledge from these interventions.

The above finding points to a structural imbalance between rural and urban areas, with urban environments seemingly presenting more opportunities for parents to educate themselves than their rural counterparts. These structural differences are evident from the South African Census statistics of 2011, which reveal that Umnini has low literacy and education levels, especially amongst the older population, while Queensburgh has higher educational and literacy levels. In South African families, like anywhere else, the level of education has been linked to socio-economic status, with higher education levels being related to higher socio-economic status, and the inverse being true (Vilanculos & Nduna, 2017).

Socio-economic status has been found to have an effect on parent-child communication on sexuality before, where parents of a lower socio-economic status were found to communicate less with their adolescents on issues of sexuality (Kuo *et al*, 2016; Meschke, Bartholomae & Zentall, 2002; Namisi *et al*, 2015; Pop & Rusu, 2015; Vilanculos & Nduna, 2017). In this study, the less educated older rural parents (the highest education level in this group was grade 4 - previously referred to as standard 6 in South Africa) were the parents that reported the least amount of communication with their adolescents overall.

It has been argued that health communication scholars and practitioners need to consider the structural constraints that might exist in a community's environment when planning for interventions (Dutta-Bergman, 2005). In the rural context of Umnini, the structural context limits parents' access to information and resources on ASRH. Any intervention, therefore, that overlooks this constraint is bound to be fraught with challenges. Research has shown that structural vulnerabilities that are a result of social, legal, power, or political inequalities often prevent people from effectively engaging in solving community health problems (Malik, 2014). Interventions on parent-child

communication on sexuality that are implemented in this context need to engage cultural members in continued dialogue to identify solutions to such challenges.

Parents who attempted communication with adolescent children realised that discussions on sexuality were often met with resistance. Adolescent children would either avoid reciprocating communication or prevent attempts at communication by saying that they learn about issues of sexuality at school, or that they were not sexually active. A possible explanation for this finding could be what was found in other studies in South Africa (Soon *et al*, 2003) and in Tanzania (Wamoyi *et al*, 2010) where adolescents reported fearing the hostile tone that parents adopted in such discussions, and so would decide not to engage fully when parents initiate communication as they feared subsequent punishment for expressing their opinions on issues of sexuality. In seeking to understand the same phenomenon found in their study with parents in KwaZulu-Natal and the Eastern Cape, Vilanculos and Nduna (2017) suggest that this non-engagement by adolescents may be culturally influenced, noting that in the Zulu and Xhosa cultural contexts, fear towards parents is equated to respect. Adolescents may therefore be avoiding communication in order to maintain those cultural boundaries of respect and adherence to parental rule.

Consequently, this then gives rise to the dilemma that if parent-child communication on sexuality is seen to be a necessary strategy to curb the challenge of adolescent pregnancy, how can it be promoted within contexts where such cultural complexities exist? The CCA to health communication negates the culture-as-barrier approach, where local cultures are seen as barriers to be overcome through the imposition of Western values (Dutta, 2008). Instead, the CCA proposes that the voices of cultural members should be central in achieving meaningful change. A cultural understanding of this phenomenon of adolescents avoiding communication on sexuality with parents may be pointing to a limitation of the dominant cultural system where adolescents are expected to be open to communicating with parents on issues of sexuality.

Several scholars have pointed to the fact that sexuality communication in most African contexts has traditionally not been seen as the responsibility of parents only, but is also a responsibility that was usually shared amongst other adults within the family, such as aunts, grandparents, uncles, cousins and older siblings (Buthelezi, 2004; Delius & Glaser, 2002; Gumede, 1978; Hunter, 2004; Kayongo-Male & Onyango, 1984). Indeed, some scholars have argued that the role of the extended family should be considered and reinforced in African contexts (Bastien *et al*, 2011; Kuo *et al*, 2016; Vilanculos & Nduna, 2017). Further research may need to be conducted to explore strategies that involve extended family members, and not necessarily the parents, in communicating to adolescents about sexuality. This would still maintain the family as the primary source of education and guidance on sexuality, but further ensure that communication happens with those members of the family that adolescents find easier to communicate with. This strategy could be implemented with all groups of parents involved in this study, as parents in all four FGDs reported this phenomenon.

Parents' accounts also revealed that communication on sexuality was characterised by the use of fear tactics, vague warnings and threats of negative sexual health outcomes such as pregnancy, STIs and even death. No differences were observed in terms of the age or the location of the parents with regards to these findings. Parents in this study could therefore benefit from interventions that have been proven to alter the communication style and tone of parents by providing them with a wider range of strategies to initiate communication on sexuality, such as the *Sisters for Life* programme that was implemented in Limpopo province, South Africa (Phetla *et al*, 2008), and the CHAMP programme that was implemented in KwaZulu-Natal (Bhana *et al*, 2004).

Parent-child communication on sexuality in this study was also found to be gendered in three ways. Firstly, conflicting messages are provided for boys and girls, with sexual activity being prohibited for girls, while being overlooked for boys. This was more prominent in the younger rural and older rural FGDs,

where parents were open to discussing sex related matters with their sons, but not with their daughters. This finding is common in other studies conducted elsewhere (Nambambi & Mufuna, 2011; Wamoyi *et al*, 2010).

There is documented evidence that suggests that SRH interventions that do not address issues of gender are not effective, whereas those that do have been found to produce positive reproductive health outcomes for adolescents and young people (Haberland & Rogow, 2015). Interventions targeting parents on parent-child communication on sexuality need to incorporate gender issues in a way that helps parents communicate similar messages for both boys and girls, especially with rural parents. It has been stated, as well, that efforts to address gender norms need to connect to other efforts with overlapping goals in other sectors (Haberland & Rogow, 2015). This further underscores the importance of designing interventions within a social ecology model that takes into cognisance the multiple levels of influence that impact on individual behaviour.

Findings from the current study also reveal that mothers communicated about sexuality issues more than fathers. Some fathers (in younger and older urban FGDs) detracted from this trend, and reported communicating with their adolescents. In contrast, older rural fathers reported no communication, and further stated that it is the mother's responsibility to communicate with all children, both boys and girls, as they spend more time with the adolescents. This finding, where mothers communicate more than fathers in matters of adolescent sexuality has been made in other studies, in both African and Western contexts (Ballard & Gross, 2009; Bastien *et al*, 2011; Nambambi & Mufune, 2011).

The phenomenon of fathers communicating with their adolescent children about sexuality issues is unique in this study, as it has not been found in other studies before. In this study, this trend was observed solely among urban fathers. This finding presents a unique window of opportunity for further research into how urban fathers perceive their role in parent-child communication on adolescent sexuality. Results from such an enquiry may

shed light on factors that motivate fathers to take on this educational role in their adolescents' lives.

As also found in a recent study conducted by Vilanculos and Nduna (2017) in three provinces in South Africa, including KwaZulu-Natal, mothers tended to communicate with girls, and fathers with boys. This finding was common across all FGDs conducted for this study. Indeed, sexuality education in the African cultural context has traditionally occurred along gendered lines, with female adults communicating with girls, and male adults communicating with boys (Buthelezi, 2004; Delius & Glaser, 2002; Gumede, 1978; Hunter, 2004; Kayongo-Male & Onyango, 1984;). Adolescents also reported being comfortable communicating with a same-sex parent (Soon *et al*, 2016; Vilanculos & Nduna, 2017). Considering the fact that large numbers of households in South Africa are headed by single parents, this is an area that warrants further investigation as it poses a challenge for adolescents that are in these households (StatsSA, 2017). In this study, some parents were already contemplating their own solutions to this challenge when they reported contemplating using other resource persons in their social and professional circles who could facilitate discussions on issues that they felt uncomfortable discussing due to this gender disparity. The study by Weekes, Haas and Gosselin (2014) could also offer lessons for future practice in this instance, as it showed that given the right tools and support, mothers were able to successfully engage in communication on sexuality with their adolescent sons.

Parents in another study indicated that they would gain from mediated family interventions where they could engage in communication with the help of a more knowledgeable person, as they felt that they could not initiate this communication on their own (Kuo *et al*, 2016).

Objective 2

To investigate factors that parents perceive as enabling or restrictive in establishing and maintaining parent-child sexuality communication

This objective sought to explore the structural and cultural factors that enable or restrict parents' ability to communicate with their adolescents on sexuality. Parents' accounts revealed that their communication on sexuality is influenced by their religious and cultural beliefs and values.

Cultural and religious beliefs had a significant role in informing the topics that parents communicated about with their adolescents. Out of the three topics that were the focus of this study, namely; pubertal changes, intimate relationships and contraception, contraception was the least discussed topic, with parents stating that this was because discussing contraception was against their culture or against their religious beliefs. There were also expressions of fear that talking about contraception with adolescents might encourage early sexual debut. Where contraception was discussed, it was due to adolescents asking questions, and parents reported that they responded by discouraging its use, thereby encouraging their adolescents to adopt the ideal of sex after marriage. In most cultures, "virginity is a normative prerequisite for marriage and family honour" (Sundby, 2006:358).

The cultural argument related to the practice of *ilobolo* (bride price) was mainly expressed by older rural parents, who felt that promoting contraception for adolescents goes against their culture. They, therefore, reported promoting the use of contraception only after their adolescents had fallen pregnant, with the promotion of contraception being to prevent further pregnancies.

This finding has not been reported in other studies elsewhere, including in studies conducted with parents in rural areas of KwaZulu-Natal (Bhana *et al*, 2004; Bhana *et al*, 2014; Vilanculos & Nduna, 2017). It is a finding that echoes Dutta's (2008:38) assertion that "narratives of health become meaningful when understood in terms of culture". It is further evidence of the benefits of working within a Culture-Centred Approach that foregrounds the voices of communities that may have been silenced by the dominant Western

discourse on health communication. In addition, this finding foregrounds the importance of health communication interventions that are designed based on the SEMCHB, which recognises the influence of multiple levels on individual behaviour.

While parent-child communication is a phenomenon that happens at an individual family level, it is highly influenced by cultural beliefs and practices that are shared communally. This is supported by Dutta-Bergman's (2005:107) assertion that "the role of culture might be particularly highlighted in collectivist cultures in which individual decision making is simply a reflection of cultural mores and rituals". As a result, while parents may benefit from interventions that equip them with knowledge and information on contraception, it is clear that this knowledge may not be used due to this cultural belief around the use of contraception.

Furthermore, regarding the above finding, interventions that target the extended family may be useful, as adolescents may still gain useful information on contraception from older siblings who may not hold such beliefs. Peer-to-peer interventions may also be better suited to facilitate discussions on contraception, as peers may hold more understanding attitudes towards the use of contraception by their fellow peers. However, in keeping with the SEMCHB, interpersonal communication efforts at promoting the use of contraception by adolescents need to be implemented across all levels, and influence not only policy, but also service provision at health facilities to ensure that adolescents are able to access and utilise contraceptive services once they are informed about them.

The practice of virginity testing also featured prominently in older rural parents' discussions. Generally, it was expressed by these parents that they felt more at peace if their daughters attended virginity testing. This practice can also be regarded as a barrier to open communication as older rural parents may be relying on the fact that their adolescent daughters are getting tested, and so believe that there is no need for further communication on issues of sexuality. However, there was evidence of some older rural parents

questioning the over-reliance on virginity testing, but instead opting to initiate discussions with their daughters on the importance of personal responsibility for the sexual decisions that they may take. In explaining the concept of agency, Bandura (2006:164) asserts that “people are self-organising, proactive, self-regulating, and self-reflecting...they are not simply onlookers of their behavior”. Similarly in this study, it is apparent that although older rural parents may value the practice of virginity testing, they are, at the same time, self-reflecting and able to critically evaluate this practice for its continued relevance in the prevention of unplanned pregnancies amongst adolescents.

Clearly, interventions targeting parents in relation to parent-child communication on sexuality cannot ignore the role that is played by cultural beliefs and practices on parents’ perceptions of contraception, as doing so may not yield the desired results. Cultural influences on parent-child communication on sexuality have been noted in other studies as well, and they point to a need for further investigation into how interventions can be designed in a way that acknowledges the role of culture in informing parents’ approaches to parent-child communication on sexuality (Izugbara, 2008; Nambambi & Mufuna, 2011; Soon *et al*, 2017; Vilanculos & Nduna, 2017).

Urban parents, on the other hand, reported not being influenced by cultural practices and beliefs in their communication on contraception. Instead, participants from the urban setting reported how they pick and choose what suits them in terms of cultural practices and beliefs, displaying a tendency towards acculturation, where they adopted a hybrid mix of cultural and what may be termed modern values. The need for interventions to assess the level of acculturation of a community in order to develop meaningful health communication programmes for them, has been stated by Dutta (2008). This is an area that may be of interest to future researchers, as it may provide insights into how acculturation affects parents’ receptiveness to parent-child communication on sexuality. Communication on contraception was avoided by urban parents mainly due to the perception that discussions about contraception was tantamount to giving their adolescents permission to

engage in pre-marital sex, something that they view as being contrary to their religion.

An enabler that was identified by younger rural, younger urban, and older urban parents was the media. Participants reported that programmes that parents and their adolescents watch on television, or hear on the radio spark most discussions on issues of sexuality. This was reported by younger rural, younger urban and older urban parents, and not by older rural parents. This finding could provide direction for future interventions that may be planned to support parents in initiating parent-child communication on sexuality. A study conducted by Weekes *et al* (2014) explored the use of a multi-media intervention package that included a compact disc (CD), and other supporting materials, which were designed to assist mothers in initiating discussions with their adolescent sons. Both mother and son would listen to the CD, which contained stories designed to trigger discussion on a sexuality related issue. The results of this intervention revealed that using this multi-media approach improved the mothers' self-efficacy in talking about sex with adolescents. This study was conducted with African American mothers in the United States. Efforts to replicate such a programme in the African context need to be undertaken with caution, and must consider the unique opportunities and challenges that the African cultural context presents.

Objective 3

To identify factors that parents perceive as necessary for them to be able to initiate and maintain parent-child sexuality communication with their adolescent children.

The last objective of this study was to ascertain what parents feel is needed in order to be successful in communicating on issues of sexuality with their adolescent children. Parents in all four FGDs felt that in order to successfully initiate and maintain communication on sexuality with their adolescent children, they needed information on pubertal changes and contraception. They also expressed the need for information on child development, so that they could better understand their children, especially at the stage of adolescence. Parents also mentioned that they needed information on age-

appropriate information that they could share with their adolescents. A study with parents in the US also reported similar findings (Ballard & Gross, 2009).

Parents also stated that they needed the skills that would enable them to initiate discussions, as well as strategies to overcome embarrassment when talking to their adolescent children. They felt that these skills could be provided through learning platforms that are suited to their lifestyles and structural circumstances. Rural parents preferred face-to-face workshops and support group sessions, while urban parents preferred a combination of face-to-face, and online platforms on social media. Some urban parents expressed the need for capacity building sessions that would combine technical information with their faith, as they felt that it was important for their communication on sexuality to be grounded in their faith.

Except for the idea for sessions that involve both parents and adolescents, the above-mentioned ideas by parents in this study are similar to what some parents have expressed in other studies. Parents that participated in the study by Ballard and Gross (2009) in the United States, and by Kuo *et al* (2016) in South Africa also expressed similar needs, with Kuo *et al* (2016) recommending that efforts at empowering parents to initiate and maintain parent-child communication on sexuality should build the efficacy and behavioural skills of parents.

The school was perceived both as an ally and a foe by most parents in all four FGDs. Parents in the rural context relied on the school and other community-based organisations to communicate sexuality messages with their adolescent children, while parents in the urban context wanted to be the primary educators, and to ensure that they complemented the school in their efforts to communicate. However, all parents reported tension between the home and the school. While on the one hand, parents were happy that their adolescents were receiving sexuality education at school, on the other hand, they viewed the school with suspicion, questioning the distribution of condoms, as well as the fact that adolescents are taught about contraception at school.

The above is an indication that while attempts have been made in the South African context to influence the macro environment of policy and practice at community level, the interpersonal communication component of parent-child communication on sexuality has not been fully integrated into this strategy. Attempts to incorporate parents into health communication strategies addressing the unacceptably high levels of adolescent pregnancy must be implemented in a way that will create synergy between what is communicated in the home and what is communicated at schools and other external institutions at the community level.

The SEMCHB states that behaviour is influenced by multiple levels of intrapersonal, interpersonal, community, and policy environments (Kincaid *et al*, 2007). While parent-child communication on sexuality is an interpersonal communication strategy, it cannot be implemented in isolation from the broader context that individuals are part of.

Conclusion

This discussion chapter shows how parents' agency is indeed enacted at the intersection between culture and structure, as Dutta (2008) maintains. While parents demonstrate agency in attempts to initiate parent-child communication on sexuality, their agency is restricted by cultural and structural constraints that prevail in their respective rural and urban contexts. Regardless of this factor, however, parents are not only actively engaging in communication currently, but they have ideas and opinions on how their role can be improved in this regard, and are able to provide their own solutions to the challenges that they face in communicating about these issues with their adolescent children.

As discovered in studies by Dumka (2006) and Vilanculos and Nduna (2017), older rural parents who were also of a lower socio-economic status, were found to have diminished self-agency to initiate and maintain effective parent-child communication on sexuality. Younger rural, younger urban and older

urban parents exhibited similar patterns of agency as they equally reported on the various attempts that they make at communicating with their adolescents.

As much as parents recognise the problematic nature of adolescent pregnancy, and report how negatively it affects not only them as adults, but also society at large, their ability to intervene is curtailed by their cultural context which informs their cultural and religious beliefs. The findings of this study confirm Dutta's (2008) contention that health communication interventions need to take cognisance of the fact that health and illness are embedded within cultural beliefs, values and practices that are contextualised within localised contexts. As a result, he advocates for a Culture-Centred Approach to health communication that actively engages community members in interpreting culturally situated problems and their solutions in a participatory process. In this study, that would mean that programme planners do not engage in this process of listening only to retreat and formulate solutions on their own, but rather engage community members in formulating their own solutions, in a process of dialogue where they are able to articulate their needs and perceived solutions.

Furthermore, this study revealed structural impediments that exist, especially for rural parents, who have much lower educational and socio-economic status than their urban counterparts. Where urban parents report having access to resources such as books, the Internet, and specialists with requisite knowledge on adolescent sexuality, younger rural parents report having access to community-based organisations that provide information on SRH in the community, and older rural parents do not report having any access to either resources or information.

Older urban parents in this study stand out as being the one group that is most adversely affected by structural impediments. Their educational levels ranged from no formal education to grade six (standard eight), meaning that their access to resources and information is largely curtailed by this fact. Dutta (2008:203) suggests what he calls a "subaltern rewriting" of health communication where researchers, students and practitioners engage with

subaltern participants in order to listen to their voices about health issues that affect them. He asserts that it is only through the opening of these 'discursive ruptures' that opportunities for new solutions to community problems may emerge.

Chapter seven will present conclusions to the study.

CHAPTER SEVEN - CONCLUSION

Introduction

The aim of this study was to investigate the perceptions of parents on the concept of parent-child communication on sexuality in eThekweni Municipality in KwaZulu-Natal province. Prior literature had indicated that there were differences in perceptions between rural and urban parents, as well as between parents younger than 45 years of age, and those older than 45 years of age (Akinwale *et al*, 2009; Vilanculos & Nduna, 2017). As a result, input was sought from four types of groups; (1) Younger Rural parents, (2) Older Rural parents, (3) Younger Urban parents, and (4) Older Urban parents, using focus group discussions as a data collection method.

This study applied the SEMCHB as advanced by Kincaid *et al* (2007), to place the concept of parent-child communication on sexuality within a broader, multi-level framework of efforts to influence adolescents' sexual health behaviour and practices. This was based on the understanding that health communication interventions that are directed at the individual level only are unlikely to yield positive results, as individual behaviour is influenced by a myriad of factors that span across the family, community, as well as the policy levels (Kincaid *et al*, 2007).

The Culture Centred Approach (CCA) to health communication was also applied because this study is situated within the field of cultural and health communication studies. The Culture-Centred Approach highlights the agency of cultural participants and their ability to frame communication strategies by foregrounding their voices through authentic dialogue (Basu & Dutta, 2009). This study engaged research participants in this process of dialogue in order to improve understanding of their perceptions of parent-child communication on sexuality, from their cultural perspectives. This engagement took the form of focus group discussions that were conducted with all four groups of parents identified for the study. Data were generated from this exercise, and an analysis of the data revealed some pertinent findings, which are summarised

below.

Summary of key findings

The FGDS that were conducted for this study revealed interesting findings, some of which were similar to others in other studies, but with some findings that are unique to this particular study. This section provides a summary of findings, limitation to the study, as well as recommendations for future research.

The nature of parent-child communication on sexuality

Findings of this study revealed that parents were engaging in what they believed to be communication on sexuality, albeit at different levels. The following characterised current communication between parents and their children on sexuality:

- Adolescents did not reciprocate communication by parents, where it occurred. This was similar across all the four FGDs;
- Some parents avoided discussions on sexuality with their adolescents.
- Parents reported using fear tactics, vague warnings and threats to discourage their children from engaging in sexual activities. This was reported by all parents in all FGDs;
- Parents give contradictory messages for girls and boys, prohibiting and policing sexual activity for girls, while condoning it among boys. Mothers are the ones that communicate with children, while fathers mainly remain silent. The exceptions to this were some urban fathers who reported communicating with their children on issues of sexuality. Mothers also preferred to communicate with girls, and fathers with boys. All parents in all the FGDs displayed this trait;
- Parents are selective in the topics on sexuality that they discuss with their children, with contraception being the least discussed topic in all the four groups identified;
- Parents use opportunities provided by television, radio, and other forms of media to initiate discussions on topics related to sexuality. Older rural parents were the only group that did not report this finding;

Cultural and structural factors that influence parent-child communication on sexuality

The communication that parents have with their adolescent children on sexuality is influenced by cultural and religious beliefs that parents hold.

- Parents' own upbringing influenced parent-child communication on sexuality. All parents, across all the four FGDs did not receive any communication from their own parents while growing up. Younger rural, younger urban and older urban parents were inspired to do better with their own children because of this, while older rural parents did not communicate with their children as a result of their own past upbringing.
- Culture played a big role in influencing older rural parents' communication with their adolescent children.
- Younger rural, younger urban and older urban parents reported that they pick and choose those cultural practices that suit their value systems.
- Structural imbalances resulted in rural parents having access to fewer resources that enhance communication than urban parents.
- All the parents across the four FGDs reported that their religion influences what they communicate about with their children, as their main focus is to instill values that are in line with their religious beliefs.

Factors for success

The last objective of this study was to ascertain what parents feel is needed in order to be successful in communicating on issues of sexuality with their adolescent children. Most studies that explored the perceptions of parents on parent-child communication did not explore parents' ideas for possible solutions, expressed by parents themselves, and taking into consideration their cultural and structural contexts. This study sought to further shed light on parents' own visualised strategies for increasing their agency to communicate with their adolescent children on issues of sexuality.

Parents were able to articulate their needs as follows:

- Parents need learning platforms that are suited to their lifestyles and structural circumstances.
- Parents need resources and information, delivered in ways that suit them. Rural parents preferred face-to-face workshops and support group sessions, while urban parents preferred a combination of face-to-face, and online platforms on social media.
- Parents do not only want information, but also information that is aligned to their cultural and religious values and beliefs.

The findings of this study reveal that parents are making attempts at communicating on issues of adolescent sexuality, although they face some barriers. Findings also reveal that parents are constantly seeking better ways in which this communication can be improved. Parents' perceptions and practices of communication with their adolescent children are influenced by their cultural beliefs and practices, in particular the meanings that they ascribe to these cultural practices and beliefs. This finding supports the CCA's assertion that individuals and communities are active participants in determining health outcomes and formulating solutions to health problems that they face (Dutta, 2011).

Structural constraints limit rural parents' opportunities and ability to communicate, while urban parents have access to a wider range of resources and information on adolescent sexuality. Socio-economic factors may be at the heart of this difference, as urban parents interviewed for this study were all employed, and had higher levels of education than their rural counterparts.

Interventions that fail to take these structural differences into consideration may fail to adequately address the different needs of parents in both contexts.

Limitations of the study

Out of the 34 participants recruited for this study, only five were male participants. However, the male participants in all FGDs participated actively and engaged fully in all discussions, and helped to provide the male perspective on all questions asked. Further research on male involvement in

parent-child communication on sexuality would be beneficial, to gain deeper insights into their perspectives on this phenomenon.

Recommendations for further research

This study foregrounded the voices of rural and urban parents in eThekweni Municipality (KwaZulu-Natal) in articulating their perceptions of parent-child communication on adolescent sexuality as a strategy to address high adolescent pregnancy levels. The study sought to explore this phenomenon from the cultural perspective of the study participants, whose voices have not been given prominence in current scholarship on parent-child communication on adolescent sexuality.

The findings from this study revealed that adolescent sexual and reproductive health is mediated by entrenched cultural beliefs and practices at the family and community level. These cultural beliefs and practices influence the topics parents feel they can or cannot communicate about. Further research is needed to explore strategies that involve the extended family including aunts, grandparents, cousins, uncles and older siblings in facilitating communication with adolescent children on issues of adolescent sexuality.

Further research is still required, which can investigate ways in which fathers can assume more responsibility for communication with their adolescent children on issues related to adolescent sexuality. Further investigation is also needed to explore strategies that will enable parents to initiate and maintain communication on sexuality with their adolescent children of an opposite sex. This study revealed that tensions exist between what parents communicate and what other external institutions of government and NGOs communicate. Research that can explore ways in which parent-child communication on sexuality can be further entrenched in multi-interventions that address adolescent pregnancy is also required.

The promise that parent-child communication on sexuality holds as an interpersonal health communication strategy can only be realised once these tensions are effectively dealt with.

Appendices

Appendix 1: Ethical Clearance Letter



10 October 2014

Ms Promise Nompumelelo Gumede (8729208)
School of Applied Human Sciences – CCMS
Howard College Campus

Protocol reference number: HSS/1303/014M

Project title: Let's talk about sex, baby – A comparative study of parents' perceptions of parent-child sexuality communication in rural and urban settings in eThekweni Municipality, KwaZulu-Natal

Dear Ms Gumede,

Full Approval – Expedited Application

In response to your application received on 02 October 2014, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Professor K Tomaselli
Cc Academic Leader Research: Professor D McCracken
Cc School Administrator: Ms Ausie Luthuli

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/6350/4557 Facsimile: +27 (0) 31 260 4009 Email: singhs@ukzn.ac.za / smymann@ukzn.ac.za / mbhuna@ukzn.ac.za

Website: www.ukzn.ac.za



Funding Colleges: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 2: Gatekeeper letter 1

DramAide is a non-profit organisation established in 1992 and based at the Universities of Zululand and KwaZulu-Natal. DramAide has a long history of theatre and youth development work in the HIV/AIDS field.

Director: Mkhonzeni Gumede
Durban Office
Hut 7, DramAide Offices
University of KwaZulu-Natal
Mazisi Kunene Ave (formerly King George V Ave)
DURBAN 4024
Tel: 031 260 1564
Fax: 031 260 1568



Zululand Office
DramAide Offices
University of Zululand
Private Bag x1001
KWADLANGEZWA 3886
Tel: 035 902 6224
Fax: 035 902 6227

RE: REQUEST TO WORK WITH DRAMAIDE ZAZI AND BROTHERS FOR LIFE GROUPS FOR MASTERS RESEARCH

Dear Nompumelelo Gumede,

Thank you for your interest in working with parents in Umnini that DRAMAIDE works with for the ZAZI and BROTHERS FOR LIFE campaigns, for your Masters Thesis in the CCMS Department.

Please note that your request has been granted. A facilitator who works with the parents' groups at Umnini will assist you to get parents who will participate in your focus group discussion.

Regards.


Lindani Hadebe
Project Manager - DRAMAIDE

Appendix 3: Gatekeeper Letter 2

THE CONGREGATIONAL CHURCH OF QUEENSBURGH

PBO No.930003102

29 Coronation Road
MALVERN
4093



Postnet Suite # 42
Private Bag X05
MALVERN
4055

20 May 2014

Dear Mpume Gumede,

Thank you for your interest in conducting your research with a group of parents from our church, on parent-child communication around issues of sexuality, for your Masters studies with CCMS at UKZN.

This is to inform you that permission is granted for you to work with a group of parents, at a date that shall be agreed upon mutually between yourself and our parents' group.

Please liaise with Mrs Nonto Khanyile for all communication regarding your study.

Best regards.

Rev C C N Khanyile

Minister: Rev Nkosi Khanyile. Tel. 031 4640499.

Appendix 4: Informed Consent Form - English

Informed consent – permission to interview.

Please note that this document is produced in duplicate – one copy to be kept by the respondent, and one copy to be retained by the researcher.

Researcher	Nompumeleo Gumede	0603754079	gumedempume3@gmail.com
Department	Centre for Culture and Media in Society (CCMS)	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)		
Supervisor	Dr Eliza Moodley	+27-31-2602635	
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	

Please do not hesitate to contact any of the above persons, should you want further information on this research, or should you want to discuss any aspect of the interview process.

Dear Participant

Thank you for taking part in this research study. Your input will add significant value in to the research project titled “Let’s talk about sex, baby - A comparative study of parents’ perceptions of parent-child sexuality communication with their adolescent children in rural and urban settings in eThekwin Municipality, KwaZulu-Natal.”

This study seeks to explore the issue of parent-child communication on selected issues of sexuality. This research is conducted by Nompumelelo Gumede (Student No: 8729208) towards her MA degree.

Please be advised that that you may choose not to participate in this research study and should you wish to withdraw at any stage, you have the full right to do so and your action will not be of any disadvantage to you in any way.

Your participation in this research will be through taking part in a focus group discussion at a venue convenient to you, and ensuring minimal disruption to your schedule. The information obtained will be treated as confidential; pseudonyms will be used in identifying respondents or participants when necessary. This will be safely stored at the University of KwaZulu-Natal, Howard College Campus.

Signed consent		
• I understand that the purpose of this interview is solely for academic purpose. The findings will be published as a thesis, and may be published in academic journals.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand I will remain anonymous. (Please choose whether or not you would like to remain anonymous.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand my name will be quoted. (Please choose whether or not you would prefer to have your remarks attributed to yourself in the final research documents.)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand that I will not be paid for participating.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand that I reserve the right to discontinue and withdraw my participation any time.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I consent to be frank to give the information.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand I will not be coerced into commenting on issues against my will, and that I may decline to answer specific questions.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I understand I reserve the right to schedule the <i>time</i> and <i>location</i> of the interview.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I consent to have this interview recorded.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
* By signing this form, I consent that I have duly read and understood its content.		
_____ Name of Participant	_____ Signature	_____ Date
_____ Name of Researcher	_____ Signature	_____ Date

Appendix 5: Informed Consent Form - IsiZulu

Informed consent – permission to interview. <i>Lelifomu kumelwe usayine elakho ozolinika umcwaningi, futhi ube nelakho ozohamba nalo.</i>			
Researcher	Nompumeleo Gumedede	0603754079	gumedempume3@gmail.com
Department	Centre for Culture and Media in Society (CCMS)	+27-31-2602505	
Institution	University of KwaZulu-Natal (UKZN)		
Supervisor	Dr Eliza Govender	+27-31-2602635	govenderel@ukzn.ac.za
Chair, UKZN Human Sciences Research Committee	Dr Shenuka Singh	+27-31-2608591	
<i>Uvumelekile ukuthinta laba ababhalwe ngenhla uma unemibuzo ngalolucwaningo, noma kukhona ofisa ukucaciseleka ngakho.</i>			

Sawubona,

Siyabonga ukuba ubambe iqhaza kulolucwaningo. Imibono yakho ibalulekile kakhulu, futhi izolekelela ukwandisa ulwazi ocwaningweni lwesihloko esithi: *“Let’s talk about sex, baby” - A comparative study of parents’ perceptions of parent-child sexuality communication with their adolescent children in rural and urban settings in eThekweni Municipality, KwaZulu-Natal.*”

Lolucwaningo luhlelelwe ukuba sibhekisise ukuxhumana phakathi kwabazali nabantwana babo, bexoxisana ngezihloko ezithinta ukuvikela kokukhulelwa, ukuthomba, kanye nokuthandana. Ucwano lwenziwa nguNompumeleo Gumedede (Student No: 8729208) ofundela iziqu ze-Masters.

Uvumelekile ukuba uhoxe ekubeni yingxenye yalolucwaningo, awuphoqiwe. Unelungelo eliphelele lokukwenza lokhu noma sesiqalile, kanti futhi lokho ngeke kube nomthelela omubi kuwena.

Ulindeleke ukuba ubambe iqhaza kulengxoxiswano ngokuveza imibono yakho. Indawo lapho ibanjwe khona lengxoxiswano, yileyo eseduze nawe ukuze ungaphazamiseki kokunye okudinga wena. Ulwazi esizoluthola kulengxoxo luyimfihlo, futhi luzogcinwa kanjalo. Uma ungafisi ukuba kubhalwe igama lakho uma sekudidiyelwa umbiko walengxoxo, uvumelekile ukusazisa ukuze sikubhale ngelinye igama ekungelona elakho. Umqulu wombiko uzogcinwa e - University of KwaZulu-Natal, Howard College Campus.

Signed consent		
<ul style="list-style-type: none"> • Ngियाqonda ukuthi inhloso yalengxoxiswano ngukuba oyihlelile afeze okwezifundo zakhe kuphela. Okuzotholaka kulengxoxiswano kuzobhalwa emqulwini obizwa nge-thesis, futhi ungase ushicilelwe ezincwadini zemfundo ephakeme. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuba igama lami alizudalulwa. (Uyacelwa ukuba ukhethe ukuba igama lakho lisetshenziswe noma qha) 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqondwa ukuba igama lami lizobhalwa maqondana nalokho engikukhulumile. (Uyacelwa ukuba ukhethe uma ufisa ukuba igama lakho lisethsenziswe.) 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuba angizukhokhelwa ngokuba yingxenye yalezingxoxo. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuba nginelungelo lokuhoxa noma kunini, ngingabe ngisaqhubeka nokuba yingxenye yalengxoxo. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyathembisa ukubeka imibono yami ngokukhululeka, nangokweqiniso. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngियाqonda ukuba angizuphoqwa ukuba ngiphawule nalapho ngingafisi khona, nanokuba ngingahoxa ukuphendula eminye imibuzo. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyavuma ukuba indawo nesikhathi salengxoxiswano anginankinga nakho. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • Ngiyavuma ukuba lengxoxiswano iqoshwe. 	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
* Ngokusayina lelifomu, ngivuma ukuba ngichazelwe ngakho konke okukulo, futhi ngakuqondisisa.		
_____	_____	_____
Igama lakho	Sayina lapha	Usuku
_____	_____	_____
Name of Researcher	Signature	Date

Appendix 6: Focus Group Discussion Guide

Objectives

The objective of this study is to explore the perceptions of parents about parent-child sexuality communication with their adolescent children. More specifically, the study aims to compare two sets of parents in different social contexts and age cohorts, i.e. rural and urban; and younger and older parents; to ascertain if there are any differences/similarities and what their nature is.

Specific objectives

4. To establish if parents are communicating with their adolescent children on issues of sexuality and to establish the nature of this communication, where it is happening;
5. To investigate factors that parents perceive as enabling or restrictive in establishing and maintaining parent-child sexuality communication;
6. To identify factors that parents perceive as necessary for them to be able to initiate and maintain parent-child sexuality communication with their adolescent children.

Research Questions

4. What is the nature of parent-child sexuality communication amongst rural and urban parents of Ethekewini Municipality in KwaZulu-Natal?
5. What are the structural and cultural factors that promote or inhibit effective parent-child sexuality communication between parents identified for this study and their adolescent children?
6. What factors do these parents perceive to be necessary for them to be effective in initiating and/or maintaining effective parent-child sexuality communication with their adolescent children?

INTRODUCTION

Welcome participants to the group and explain the purpose of this research. Do a short introductory exercise where all participants introduce themselves, and the moderator. Emphasise that the discussion will seek to obtain individual and group perspectives on parents communicating with their children on issues of prevention of pregnancy, puberty and intimate relationships.

Make labels such as M1, M2, M3 etc. that you will ask participants to wear and to introduce themselves with when making comments and during discussions. Explain that this is for our recording purposes and that individual's responses will be kept anonymous, with feedback given to stakeholders taking the form of group feedback. Add that all identifying data will be removed from transcripts and for the purposes of reports and feedback to key stakeholders.

Make it clear to participants that their views are important to us and that there are no 'right' or 'wrong' answers in the context of a focus group discussion (describe this concept further if necessary). Explain the need for recording and obtain written informed consent from participants.

Let participants know that the same focus groups are being undertaken with three other groups in urban and rural settings. Ask if there are any questions before you start. Position the recorders and start recording.

INTRODUCTORY QUESTIONS

1. What is the nature of your communication with your adolescent children?
2. What do you talk about with your children? When do you talk? How often? How do you talk? What sparks discussion mostly? Is it planned or unplanned?
3. When you were growing up, what discussions were you having with your parents?
4. How has that changed over the years?
5. Today we want to understand communication on sexuality between parents and their adolescent children, and that is why we have selected parents who have adolescent children, whether boys or girls.

RESEARCH QUESTION 1

What is the nature of parent-child sexuality communication amongst rural and urban parents of Ethekwini Municipality in KwaZulu-Natal?

1. What is the nature of your discussions on sexuality with your adolescent children (contraception, puberty, intimate relationships)? What do you talk about (probe for specific topics)? When do you talk about it? Where do you get the information? Who talks the most between fathers and mothers?
2. If you are not having these discussions with your own children, how are you ensuring that children have knowledge, and are implementing that knowledge on sexuality?
3. What are your views to parents talking about sexuality with their children?
4. What should parents talk about with their children during the stage of puberty? Why?
5. Who should talk to children about issues of sexuality? Why? Probe for when children do not live with their parents.

6. Who do you think children should talk to about issues of sexuality? Why?

RESEARCH QUESTION 2

What are the structural and cultural factors that promote or inhibit effective parent-child sexuality communication between parents identified for this study and their adolescent children?

1. Where do you as parents get information on how to talk with your children about these issues?
2. What are some of the barriers when it comes to communicating with your children about these issues? Probe for cultural, information and other resources
3. Do you feel capable of explaining the answers to questions that get asked of you when it comes to issues of puberty, pregnancy and sexual relationships?
4. What areas are you most comfortable with? Why?
5. What areas are challenging for you? Why?

RESEARCH QUESTION 3

What factors do these parents perceive to be necessary for them to be effective in initiating and/or maintaining effective parent-child sexuality communication with their adolescent children?

1. Do you feel that there is a need for parents to be taught how to communicate with their children on issues of sexuality? Why?
2. If there was programme for parents on parent-child sexuality communication, what aspects do you feel it should focus on? Why?
3. How should the programme be structured?
4. What information do you need?
5. What skills do you need?
6. What else can you think of that would enable you to better communicate with your children on sexuality issues?

CLOSING

1. Do you have any additional questions or issues that you feel are important for this study?
2. Is there anything new that you learnt from this discussion? What is it?

Bibliography

Primary Sources

Focus Group Discussion 1, younger rural parents. Moderated by Nompumelelo Gumede, in Umnini, South Africa, June 2017.

Focus Group Discussion 2, older rural parents. Moderated by Nompumelelo Gumede in Umnini, South Africa, June 2017.

Focus Group Discussion 3, younger urban parents. Moderated by Nompumelelo Gumede in Queensburgh, July 2017.

Focus Group Discussion 4, older urban parents. Moderated by Nompumelelo Gumede in Queensburgh, July 2017.

Secondary Sources

African Union. (2006). *Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa: Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health Rights 2007-2010*, Addis Ababa.

African Union. (2006). *Sexual and Reproductive Health and Rights*. Addis Ababa.

Agha, S. & Van Rossem, R. (2004). Impact of a school-based peer sexual health intervention on normative beliefs, risk perceptions, and sexual behavior of Zambian adolescents. *Journal of adolescent health*, 34, 441-452.

Airhihenbuwa, C. O., Makinwa, B., Obregon, R. 2000. Toward a new communications framework for HIV/AIDS. *Journal of Health Communication*, 5(sup1), pp.101-111.

Akinwale, O., Adeneye, A., Omotola, D., Manafa, O., Idowu, T., Adewale, B., Sulyman, M. & Akande, D. (2009). Parental perception and practices relating to parent-child communication on sexuality in Lagos, Nigeria. *Journal of Family and Reproductive Health*, 3, 123-128.

Alkire, S. (2005). Subjective quantitative studies of human agency. *Social Indicators Research*, 74, 217-260.

Aspy, C. B., Vesely, S. K., Oman, R. F., Rodine, S., Marshall, L. & Mcleroy, K.

- (2007). Parental communication and youth sexual behaviour. *Journal of adolescence*, 30, 449-466.
- Ballard, S. M. & Gross, K. H. (2009). Exploring parental perspectives on parent-child sexual communication. *American Journal of Sexuality Education*, 4, 40-57.
- Bandura, A. (1989). Human agency in social cognitive theory. *American psychologist*, 44, 1175.
- Bandura, A. (1998). Health promotion from the perspective of social cognitive theory. *Psychology and health*, 13, 623-649.
- Bandura, A. (2001). Social cognitive theory of mass communication. *Media psychology*, 3, 265-299.
- Bandura, A. (2002). Social cognitive theory in cultural context. *Applied psychology*, 51, 269-290.
- Bandura, A. 2006. Toward a psychology of human agency. *Perspectives on psychological science*, 1, 164-180.
- Bastien, S., Kajula, L. J. & Muhwezi, W. W. (2011). A review of studies of parent-child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive health*, 8, 25.
- Basu, A. & Dutta, M. J. (2009). Sex Workers and HIV/AIDS: Analyzing Participatory Culture-Centered Health Communication Strategies. *Human Communication Research*, 35, 86-114.
- Bello, B. M., Fatusi, A. O., Adepoju, O. E., Maina, B. W., Kabiru, C. W., Sommer, M. & Mmari, K. (2017). Adolescent and parental reactions to puberty in Nigeria and Kenya: A cross-cultural and intergenerational comparison. *Journal of Adolescent Health*, 61, S35-S41.
- Bersamin, M., Todd, M., Fisher, D. A., Hill, D. L., Grube, J. W. & Walker, S. (2008). Parenting practices and adolescent sexual behavior: A longitudinal study. *Journal of Marriage and Family*, 70, 97-112.
- Bhana, A., Petersen, I., Mason, A., Mahintsho, Z., Bell, C. & McKay, M. (2004). Children and youth at risk: Adaptation and pilot study of the CHAMP (Amaqhawwe) programme in South Africa. *African journal of AIDS Research*, 3, 33-41.
- Blum, R. W. & Gates, W. (2015). *Girlhood not motherhood. Preventing adolescent pregnancy*. WHO, Geneva.

- Bornstein, M. H. & Cheah, C. S. (2006). The place of “culture and parenting” in the ecological contextual perspective on developmental science. *Parenting beliefs, behaviors, and parent-child relations: A cross-cultural perspective*, 3-33.
- Bornstein, M. H., Tal, J. & Tamis—Lemonda, C. (1991). *Cultural approaches to parenting*, The United States, France and Japan.
- Boyer, C. B., Sieverding, J., Siller, J., Gallaread, A. & Chang, Y. J. (2007). Youth united through health education: Community-level, peer-led outreach to increase awareness and improve noninvasive sexually transmitted infection screening in urban African American youth. *Journal of adolescent health*, 40, 499-505.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3, 77-101.
- Brieger, W. R., Delano, G. E., Lane, C. G., Oladepo, O. & Oyediran, K. A. (2001). West African Youth Initiative: outcome of a reproductive health education program. *Journal of Adolescent Health*, 29, 436-446.
- Buthelezi, T. (2004). Lexical reinforcement and maintenance of gender stereotypes in isiZulu. *Alternation*, 11, 386-400.
- Casimir, F. L. (1991). Introduction: Culture, Communication, and Education. *Communication Education*, 40, 229-34.
- Chandra-Mouli, V., Camacho, A. V. & Michaud, P.A. (2013). WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. *Journal of Adolescent Health*, 52, 517-522.
- Chandra-Mouli, V., Lane, C. & Wong, S. (2015). What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. *Global Health: Science and Practice*, 3, 333-340.
- Cohen, D. A., Scribner, R. A. & Farley, T. A. (2000). A structural model of health behavior: a pragmatic approach to explain and influence health behaviors at the population level. *Preventive medicine*, 30, 146-154.
- Cupples, J. B., Zukoski, A. P. & Dierwechter, T. (2010). Reaching young men: lessons learned in the recruitment, training, and utilization of male peer sexual health educators. *Health Promotion Practice*, 11, 19S-25S.

- Davis, K. C., Blitstein, J. L., Evans, W. D. & Kamyab, K. (2010). Impact of a parent-child sexual communication campaign: results from a controlled efficacy trial of parents. *Reproductive health*, 7, 17.
- Deacon, D., Pickering, M., Golding, P. & Murdock, G. (1999). Counting Contents' and 'Analyzing Texts' in Deacon et al. *Researching Communications: A practical guide to methods in media and cultural analysis*, 185-195.
- Degner, A. J. (2006). The definition of adolescence: One term fails to adequately define this diverse time period. *CHARIS: A Journal of Lutheran Scholarship, Thought, and Opinion*, 5, 7-8.
- Delius, P. & Glaser, C. (2002). Sexual socialisation in South Africa: a historical perspective. *African Studies*, 61, 27-54.
- Denzin, N. K. & Lincoln, Y. S. (2008). *The landscape of qualitative research*, Sage.
- Department of Social Development. (2015). National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy (2014-2019). Pretoria.
- Dilorio, C., Pluhar, E. & Belcher, L. (2003). Parent-child communication about sexuality: A review of the literature from 1980–2002. *Journal of HIV/AIDS Prevention & Education for Adolescents & Children*, 5, 7-32.
- Dumka Larry, E. L. (1996). Examination of the Cross-Cultural and Cross-Language Equivalence of the Parenting Self-Agency Measure. *Family Relations*, 45, 216.
- Durden, E. & Govender, E. (2012). *Investigating communication, health and development: 10 years of research in the Centre for Communication, Media & Society*. Auckland Park: Jacana Media Ltd.
- Dutta, M. J. (2008). *Communicating health*, Cambridge, UK; Malden, MA, Polity.
- Dutta, M. J. (2011). *Communicating social change : structure, culture, and agency*, New York, Routledge.
- Dutta-Bergman, M. J. (2005). Theory and practice in health communication campaigns: A critical interrogation. *Health communication*, 18, 103-122.
- Eberhardt, M. S. & Pamuk, E. R. (2004). The importance of place of residence: examining health in rural and nonrural areas. *American journal of public health*, 94, 1682-1686.
- Eisenberg, M. E., Sieving, R. E., Bearinger, L. H., Swain, C. & Resnick, M. D. (2006). Parents' communication with adolescents about sexual behavior: A missed

- opportunity for prevention? *Journal of Youth and Adolescence*, 35, 893-902.
- Embong, A. R. (2011). The question of culture, identity and globalisation: An unending debate. *Kajian Malaysia: Journal of Malaysian Studies*, 29.
- Emelumadu, O., Ezeama, N., Ifeadike, C., Ubajaka, C., Adogu, P., Umeh, U., Nwamoh, U., Ukegbu, A. & Onyeonoro, U. (2014). Parents' Perceptions of Timing of Initiation of Sexuality Discussion with Adolescents in Anambra State, South Eastern Nigeria. *Journal of pediatric and adolescent gynecology*, 27, 294-300.
- eThekwini Municipality. (2015). *Integrated Development Plan: eThekwini Municipality*. Durban.
- Esere, M. O. (2008). Effect of sex education programme on at-risk sexual behaviour of school-going adolescents in Ilorin, Nigeria. *African Health Sciences*, 8.
- Flay, B. R., Snyder, F. & Petraitis, J. (2009). The theory of triadic influence. *Emerging theories in health promotion practice and research*, 2, 451-510.
- Freire, P. (1970). *Pedagogy of the oppressed*, New York, Seabury Press.
- Frisco, M. L. (2005). Parental involvement and young women's contraceptive use. *Journal of Marriage and Family*, 67, 110-121.
- Fuchs, C. (2015). Surveillance and critical theory. *Media and Communication*, 3, 6-9.
- Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., Yamdamsuren, B., Temmerman, M., Say, L. & Tunçalp, Ö. (2014). Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study. *BJOG: An International Journal of Obstetrics & Gynaecology*, 121, 40-48.
- Gay, E. (2017). *The Demographic Dividend in Africa Relies on Investments in the Reproductive Health and Rights of Adolescents and Youth*. Population Reference Bureau, Connecticut.
- Glanz, K., Rimer, B. K. & Viswanath, K. (2008). *Health behavior and health education : theory, research, and practice*, San Francisco, CA, Jossey-Bass.
- Govender, E. M. (2011). Development and health communication for HIV/AIDS prevention. In: TOMASSELLI, K. C., C. (ed.) *Development and public health communication*. Cape Town: Pearson Education
- Gray, D. E. (2013). *Doing research in the real world*. Sage.
- Guba, E. G. & Lincoln, Y. S. (1994). *Competing paradigms in qualitative research*, Thousand Oaks, CA, Sage.

- Guha, R. (2001). Subaltern studies: Projects for our time and their convergence. *The Latin American subaltern studies reader*, 35-46.
- Gumede, M. (1978). Maternal and child health care delivery-traditional Zulu practitioners and obstetric medicine. *South African Medical Journal*, 53, 823-825.
- Haberland, N. & Rogow, D. (2015). Sexuality education: emerging trends in evidence and practice. *Journal of adolescent health*, 56, S15-S21.
- Hindin, M. J. & Fatusi, A. O. (2009). Adolescent sexual and reproductive health in developing countries: an overview of trends and interventions. *International perspectives on sexual and reproductive health*, 35, 58-62.
- Hook, D., Franks, B. & Bauer, M. W. (2011). *The social psychology of communication*. Houndmills, Basingstoke, Hampshire; New York, Palgrave Macmillan.
- Hunter, M. (2004). Masculinities, multiple-sexual-partners, and AIDS: the making and unmaking of Isoka in KwaZulu-Natal. *Transformation: critical perspectives on Southern Africa*, 54, 123-153.
- Hyde, A., Carney, M., Drennan, J., Butler, M., Lohan, M. & Howlett, E. (2009). Parents' Approaches to Educating their Pre-adolescent and Adolescent Children about Sexuality. University College, Dublin and Queen's University, Belfast.
- Izugbara, C. O. (2008). Home-based sexuality education: Nigerian parents discussing sex with their children. *Youth & Society*, 39, 575-600.
- Jaccard, J., Dodge, T. & Dittus, P. (2002). Parent-adolescent communication about sex and birth control: A conceptual framework. *New directions for child and adolescent development*, 2002, 9-42.
- Jordan, T. R., Price, J. H. & Fitzgerald, S. (2000). Rural Parents' Communication With Their Teen-agers About Sexual Issues. *Journal of School Health*, 70, 338-344.
- Kalembo, F. W., Zgambo, M. & Yukai, D. (2013). Effective adolescent sexual and reproductive health education programs in sub-Saharan Africa. *Calif J Health Promot*, 11, 33-42.
- Kamangu, A. A., John, M. R. & Nyakoki, S. J. (2017). Barriers to parent-child communication on sexual and reproductive health issues in East Africa: A

- review of qualitative research in four countries. *Journal of African Studies and Development*, 9, 45-50.
- Kaplan, P. S. (2004). *Adolescence*. Boston, Houghton Mifflin Company.
- Karacan, E. (2014). Timing of Parenthood and Generativity Development: An Examination of Age and Gender Effects in Turkish Sample. *Journal of Adult Development*, 21, 207-215.
- Kaufman, C. E., Clark, S., Manzini, N. & May, J. (2004). Communities, Opportunities, and Adolescents' Sexual Behavior in KwaZulu-Natal, South Africa. *Studies in family planning*, 35, 261-274.
- Kayongo-Male, D. & Onyango, P. (1984). *The sociology of the African family*, London; New York, Longman.
- Kim, Y. M., Kols, A., Nyakauru, R., Marangwanda, C. & Chibatamoto, P. (2001). Promoting sexual responsibility among young people in Zimbabwe. *International family planning perspectives*, 11-19.
- Kincaid, D., Figueroa, M., Storey, D. & Underwood, C. (2007). *A social ecology model of communication, behavior change, and behavior maintenance. Working paper. Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.*
- Kitzinger, J. (1995). Qualitative research. Introducing focus groups. *BMJ: British Medical Journal*, 311, 299.
- Kitzinger, J. & Barbour, R. (1999). *Developing focus group research: Politics, theory and practice*. London, Sage.
- Kreuter, M. W. & McClure, S. M. (2004). The role of culture in health communication. *Annu. Rev. Public Health*, 25, 439-455.
- Krueger, R. & Casey, M. (2015). Participants in a focus group. *Focus Groups A Practical Guide for Applied Research*, Sage Publications, Inc, USA.
- Kubota, R. & Miller, E. R. (2017). Re-Examining and Re-Envisioning Criticality in Language Studies: Theories and Praxis. *Critical Inquiry in Language Studies*, 1-29.
- Kulis, S., Ayers, S. L. & Baker, T. (2015). Parenting in 2 Worlds: Pilot results from a culturally adapted parenting program for urban American Indians. *The journal of primary prevention*, 36, 65-70.
- Kuo, C., Atujuna, M., Mathews, C., Stein, D. J., Hoare, J., Beardslee, W., Operario,

- D., Cluver, L. & K. Brown, L. (2016). Developing family interventions for adolescent HIV prevention in South Africa. *AIDS Care*, 28, 106-110.
- Kuruville, S., Bustreo, F., Kuo, T., Mishra, C., Taylor, K., Fogstad, H., Gupta, G. R., Gilmore, K., Temmerman, M. & Thomas, J. (2016). The Global strategy for women's, children's and adolescents' health (2016–2030): a roadmap based on evidence and country experience. *Bulletin of the World Health Organization*, 94, 398.
- Lindsay, A. C., Sussner, K. M., Kim, J. & Gortmaker, S. (2006). The role of parents in preventing childhood obesity. *The Future of children*, 169-186.
- Loaiza, E. & Liang, M. (2013). *Adolescent pregnancy: a review of the evidence*. UNFPA. New York
- Lurie, M., Pronyk, P., De Moor, E., Heyer, A., De Bruyn, G., Struthers, H., McIntyre, J., Gray, G., Marinda, E. & Klipstein-Grobusch, K. (2008). Sexual behavior and reproductive health among HIV-infected patients in urban and rural South Africa. *Journal of acquired immune deficiency syndromes (1999)*, 47.
- Malik, K. (2014). *Human development report 2014: Sustaining human progress: Reducing vulnerabilities and building resilience*, United Nations Development Programme. New York
- Manaster, G. J. (1989). *Adolescent development: A psychological interpretation*, FE Peacock Pub.
- Masinga, L. (2009). An African Teacher's Journey to Self-Knowledge Through Teaching Sexuality Education. *Counterpoints*, 357, 237-252.
- Mason-Jones, A. J., Mathews, C. & Flisher, A. J. (2011). Can peer education make a difference? Evaluation of a South African adolescent peer education program to promote sexual and reproductive health. *AIDS and Behavior*, 15, 1605.
- Maticka-Tyndale, E. & Barnett, J. P. (2010). Peer-led interventions to reduce HIV risk of youth: a review. *Evaluation and program planning*, 33, 98-112.
- Mbugua, N. (2007). Factors inhibiting educated mothers in Kenya from giving meaningful sex-education to their daughters. *Social Science & Medicine*, 64, 1079-1089.
- Mckee, N., Bertrand, J., Becker-Benton, A. & Becker, B. L. (2004). *Strategic communication in the HIV/AIDS epidemic*. London, Sage.
- Mcleroy, K. R., Bibeau, D., Steckler, A. & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health education quarterly*, 15, 351-77.

- Meggiolaro, S. & Ongaro, F. (2013). Maternal age and parenting strategies. *Genus*, LXIX, 3, 1-24.
- Melkote, S. R. & Steeves, H. L. (2001). *Communication for development in the Third World: Theory and practice for empowerment*. India, Sage.
- Merrick, T. (2016). *Making the Case for Investing in Adolescent Reproductive Health: A Review of Evidence and Poppov Research Contributions*. Washington DC, Population and Poverty Research Initiative and Population Reference Bureau.
- Meschke, L. L., Bartholomae, S. & Zentall, S. R. (2002). Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Journal of adolescent health*, 31, 264-279.
- Milford, C.,L. M., Beksinska M., Kubeka M., Smit J. (2014). Developing a community based response to promote family planning and reduce the rate of teenage pregnancy: A KwaZulu-Natal Sexual and Reproductive Health Pilot Project. Durban: Department of Obstetrics and Gynaecology, Faculty of Health Sciences, Wits Univesity.
- Miller, B. C. (2002). Family influences on adolescent sexual and contraceptive behavior. *Journal of sex research*, 39, 22-26.
- Morgan, D. L. (1996). *Focus groups as qualitative research*. California, Sage.
- Nambambi, N. M. & Mufune, P. (2011). What is talked about when parents discuss sex with children: family based sex education in Windhoek, Namibia. *African journal of reproductive health*, 15, 120-129.
- Namisi, F. S., Flisher, A. J., Overland, S., Bastien, S., Onya, H., Kaaya, S. & Aarø, L. E. (2009). Sociodemographic variations in communication on sexuality and HIV/AIDS with parents, family members and teachers among in-school adolescents: a multi-site study in Tanzania and South Africa. *Scandinavian journal of public health*, 37, 65-74.
- National Department of Health. (2013). *National Adolescent and Youth Health Policy (AYHP)*. Pretoria.
- Naugle, D. A. & Hornik, R. C. (2014). Systematic review of the effectiveness of mass media interventions for child survival in low-and middle-income countries. *Journal of health communication*, 19, 190-215.
- Obregon, C. O., Airhihenbuwa, R. (2000). A critical assessment of theories/models used in health communication for HIV/AIDS. *Journal of health communication*, 5, 5-15.

- Oishi, S. & Graham, J. (2010). Social Ecology: Lost and Found in Psychological Science. *Perspectives on Psychological Science*, 5, 356-377.
- Panday, S., Makiwane, M., Ranchod, C. & Letsoala, T. (2009). Teenage pregnancy in South Africa: with a specific focus on school-going learners.
- Panter-Brick, C., Clarke, S. E., Lomas, H., Pinder, M. & Lindsay, S. W. (2006). Culturally compelling strategies for behaviour change: a social ecology model and case study in malaria prevention. *Social science & medicine*, 62, 2810-2825.
- Parkes, A., Henderson, M., Wight, D. & Nixon, C. (2011). Is Parenting Associated with Teenagers' Early Sexual Risk-Taking, Autonomy And Relationship with Sexual Partners? *Perspectives on sexual and reproductive health*, 43, 30-40.
- Pearson, J., Muller, C. & Frisco, M. L. (2006). Parental involvement, family structure, and adolescent sexual decision making. *Sociological Perspectives*, 49, 67-90.
- Peltzer, K. (2006). Sexuality among adolescents in rural and urban South Africa. *South African Review of Sociology*, 37, 189-199.
- Perrino, T., González-Soldevilla, A., Pantin, H. & Szapocznik, J. (2000). The role of families in adolescent HIV prevention: A review. *Clinical child and family psychology review*, 3, 81-96.
- Petraglia, J. (2009). The importance of being authentic: Persuasion, narration, and dialogue in health communication and education. *Health communication*, 24, 176-185.
- Phetla, G., Busza, J., Hargreaves, J. R., Pronyk, P. M., Kim, J. C., Morison, L. A., Watts, C. & Porter, J. D. (2008). "They have opened our mouths": increasing women's skills and motivation for sexual communication with young people in rural South Africa. *AIDS Education & Prevention*, 20, 504-518.
- Pinderhughes, E. E., Nix, R., Foster, E. M. & Jones, D. (2001). Parenting in context: Impact of neighborhood poverty, residential stability, public services, social networks, and danger on parental behaviors. *Journal of Marriage and family*, 63, 941-953.
- Piotrow, P. T., Kincaid, D. L., Rimon, J. G., Rinehart, W. & Samson, K. (1997). Health Communication: Lessons from Family Planning and Reproductive health. Connecticut, Praegar.
- Pop, M. V. & Rusu, A. S. (2015). The Role of Parents in Shaping and Improving the

- Sexual Health of Children—Lines of Developing Parental Sexuality Education Programmes. *Procedia-Social and Behavioral Sciences*, 209, 395-401.
- Reddy, P., Sewpaul, R. & Jonas, K. (2016). *Teenage pregnancy in South Africa: Reducing prevalence and lowering maternal mortality rates*. Pretoria, HSRC.
- Regnerus, M. D. (2005). Talking about sex: Religion and patterns of parent–child communication about sex and contraception. *The Sociological Quarterly*, 46, 79-105.
- Rensburg, R. & Krige, D. (2011). Aspects of health communication. *Development and public health communication*. Cape Town: Pearson Education, 77-100.
- Rubin, K. H. & Chung, O. B. (2013). *Parenting beliefs, behaviors, and parent-child relations: A cross-cultural perspective*, Psychology Press.
- Sallis, J. F., Owen, N. & Fisher, E. (2015). Ecological models of health behavior. *Health behavior: Theory, Research, and Practice*. 5th ed. San Francisco: Jossey-Bass, 43-64.
- Saunders, M., Lewis, P. & Thornhill, A. (2009). Collecting primary data using semistructured, in-depth and group interviews. *Research methods for business students (5th. ed., pp. 318-359)*. Harlow: Pearson Education.
- Schouten, B. C., Van Den Putte, B., Pasmans, M. & Meeuwesen, L. (2007). Parent–adolescent communication about sexuality: The role of adolescents’ beliefs, subjective norm and perceived behavioral control. *Patient Education and Counseling*, 66, 75-83.
- Schunk, D. H. (1991). Self-efficacy and academic motivation. *Educational psychologist*, 26, 207-231.
- Sedgh, G., Finer, L. B., Bankole, A., Eilers, M. A. & Singh, S. (2015). Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends. *Journal of Adolescent Health*, 56, 223-230.
- Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22, 63-75.
- Shisana, O., Rehle, T., Simbayi, L., Zuma, K., Jooste, S., Zungu, N., Labadarios, D. & Onoya, D. (2014). *South African national HIV prevalence, incidence and behaviour survey, 2012*. Pretoria, HSRC.
- Simon, L. & Daneback, K. (2013). Adolescents’ use of the internet for sex education: A thematic and critical review of the literature. *International Journal of Sexual Health*, 25, 305-319.

- Skinner, B. F. (1953). *Science and human behavior*, New York, The Free Press.
- Soon, C. N., Kaida, A., Miller, C. L., Nkala, B., Dietrich, J., Gray, G. & Cescon, A. (2013). Adolescent experiences of HIV and sexual health communication with parents and caregivers in Soweto, South Africa: *Journal of Social Aspects of HIV / AIDS Research Alliance*, 10, 163-169.
- Spivak, G. C. (2005). Scattered speculations on the subaltern and the popular. *Postcolonial studies*, 8, 475-486.
- Statistics South Africa. (2015). *Census 2011: Fertility in South Africa*. Pretoria: Statistics South Africa.
- Statistics South Africa. (2017). *South Africa Demographic and Health Survey 2016: Key Indicator Report*, Pretoria: Statistics South Africa.
- Stokols, D. (1992). Establishing and maintaining healthy environments. Toward a social ecology of health promotion. *The American psychologist*, 47, 6-22.
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American journal of health promotion*, 10, 282-298.
- Storey, D. F. & Elena, M. (2012). *Toward a global theory of health behavior and social change*, West Sussex, Wiley-Blackwell.
- Strasburger, V. C. (2004). Children, adolescents, and the media. *Current Problems in Pediatric and Adolescent Health Care*, 34, 54-113.
- Struwig, F. & Stead, G. (2013). *Research: Planning, Designing and Reporting*. Cape Town. South Africa: Pearson.
- Sundby, J. (2006). Young people's sexual and reproductive health rights. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 20, 355-368.
- Svanemyr, J., Amin, A., Robles, O. J. & Greene, M. E. (2015). Creating an enabling environment for adolescent sexual and reproductive health: a framework and promising approaches. *Journal of Adolescent Health*, 56, S7-S14.
- Sznitman, S., Vanable, P. A., Carey, M. P., Hennessy, M., Brown, L. K., Valois, R. F., Stanton, B. F., Salazar, L. F., Diclemente, R. & Farber, N. (2011). Using culturally sensitive media messages to reduce HIV-associated sexual behavior in high-risk African American adolescents: results from a randomized trial. *Journal of Adolescent Health*, 49, 244-251.
- Turner, K. M. & Sanders, M. R. (2006). Dissemination of evidence-based parenting and family support strategies: Learning from the Triple P—Positive Parenting

- Program system approach. *Aggression and Violent behavior*, 11, 176-193.
- UNAIDS. (2017). *UNAIDS Data 2017*. Switzerland.
- UNESCO. (2013). Young people today time to act now. *Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa*. Paris, UNESCO.
- UNESCO. (2013). *Ministerial commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA)*. Cape Town.
- UNFPA, UNESCO & UNAIDS. (2015). *Fulfilling our promise to young people today: 2013-2015 Progress Review. The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people*. New York
- UNICEF. (2011). *The state of the world's children 2011: adolescence-an age of opportunity*, UNICEF. New York.
- United Nations. (2015). Resolution adopted by the General Assembly on 25 September 2015. *Washington: United Nations*.
- Vilanculos, E. & Nduna, M. (2017). "The child can remember your voice": parent–child communication about sexuality in the South African context. *African Journal of AIDS Research*, 16, 81-89.
- Wamoyi, J., Fenwick, A., Urassa, M., Zaba, B. & Stones, W. (2010). Parent-child communication about sexual and reproductive health in rural Tanzania: Implications for young people's sexual health interventions. *Reproductive Health*, 7, 6.
- Weekes, C. V., Haas, B. K. & Gosselin, K. P. (2014). Expectations and Self-Efficacy of African American Parents Who Discuss Sexuality with their Adolescent Sons: An Intervention Study. *Public Health Nursing*, 31, 253-261.
- Wight, D. & Fullerton, D. (2013). A review of interventions with parents to promote the sexual health of their children. *Journal of Adolescent Health*, 52, 4-27.
- Wilson, E. K., Dalberth, B. T., Koo, H. P. & Gard, J. C. (2010). Parents' perspectives on talking to pre-teenage children about sex. *Perspectives on Sexual and Reproductive health*, 42, 56-63.
- World Health Organisation. (2006). *Defining sexual health: report of a technical consultation on sexual health, 28-31 January 2002, Geneva*, WHO.

- World Health Organisation. (2007). *Summaries of projects in developing countries assisting the parents of adolescents*. WHO: Geneva.
- World Health Organisation. (2016). *Department of maternal, newborn, child and adolescent health (MCA): progress report 2014–15*. WHO: Geneva.
- World Health Organisation. (2017). *Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation*. WHO: Geneva.